DOCUMENT RESUME

ED 343 217 EA 023 728

TITLE	School Health: Helping Children Learn. Leadership Reports, 1991-2.
INSTITUTION	National School Boards Association, Alexandria, VA.
SPONS AGENCY	Fund for the Improvement and Reform of Schools and Teaching (ED/OERI), Washington, DC.
PUB DATE	91
NOTE	88p.
AVAILABLE FROM	National School Boards Association, 1680 Duke Street, Alexandria, VA 22314-3494 ($15.00 prepaid).
PUB TYPE	Guides - Non-Classroom Use (055) -- Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	*Child Health; Counselor Role; Educational Environment; Elementary Secondary Education; *Health Education; *Holistic Approach; Public Schools; *School Health Services; School Nurses; Teacher Role

ABSTRACT

Two major trends have affected the responsibility of the public schools in providing health education and services over the past 2 decades. First, the structure of the family and the demographics of the school-aged population have changed dramatically, placing greater burdens for child welfare on school systems. Second, the leading causes of morbidity in the United States have changed from infectious diseases to behavior-related chronic diseases (injuries, homicide, and suicide). In light of these changes, the National School Boards Association (NSBA) focusing on the needs of the whole child, a holistic approach to education, and a coordinated youth policy. This document discusses how to establish a health program that encompasses health education, health services, and healthy school environments. Several primary obstacles to implementing school programs include: (1) directives concerning health education; (2) the already-packed education agenda; (3) the fact that local needs may not be adequately considered; and (4) the impact of coordination with other agencies that provide health education and/or services. This guide aids policymakers in overcoming these obstacles by describing the elements of exemplary programs and illustrating processes for achieving them. Examples from four existing programs provide guidelines and identify resources for school board members, school administration staff, and their communities. (35 references) (LAP)

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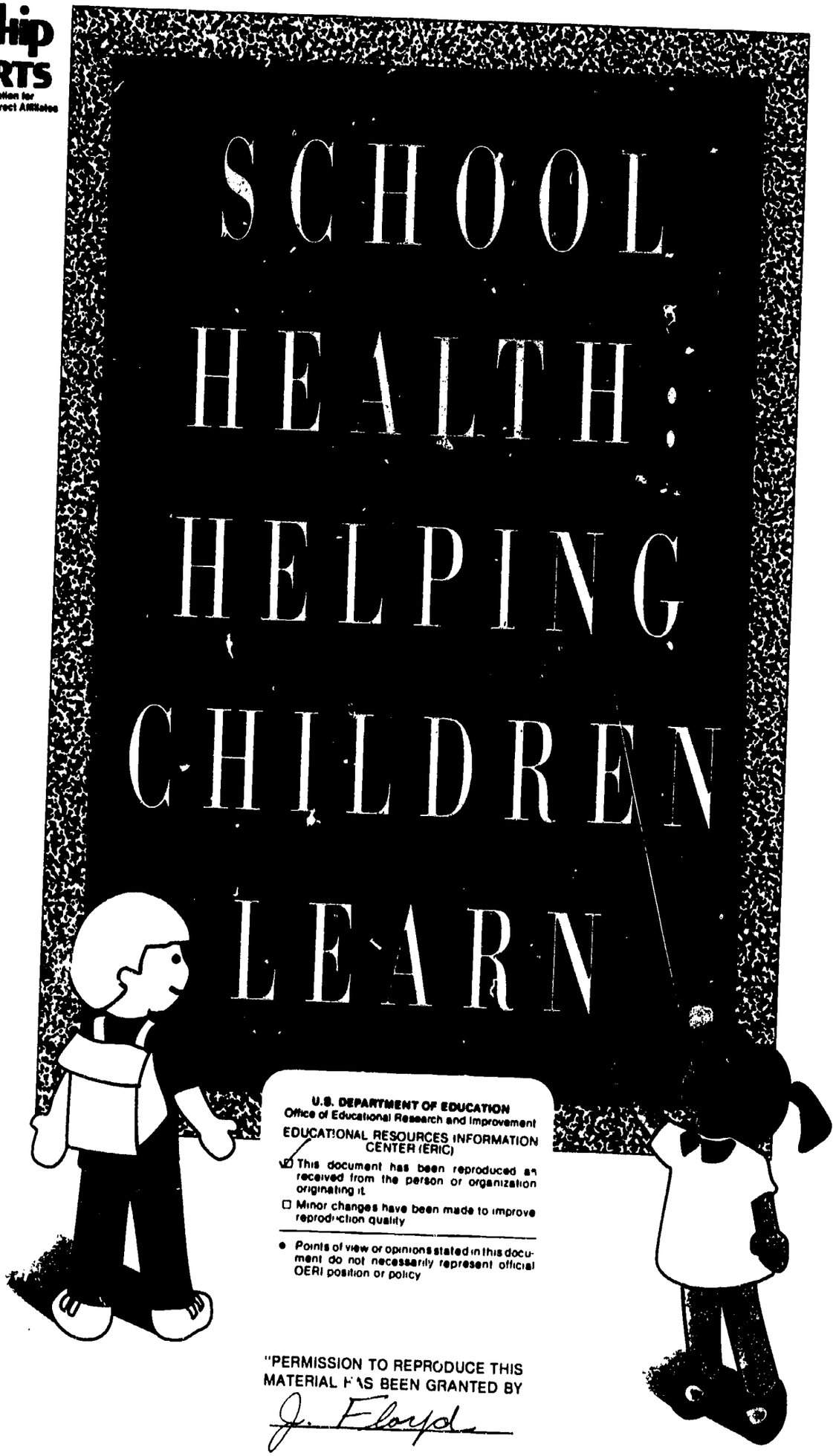

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SCHOOL HEALTH: HELPING CHILDREN LEARN

SCHOOL HEALTH: HELPING CHILDREN LEARN

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This report was completed with support provided by a grant from the U.S. Department of Education, Fund for the Improvement and Reform of Schools and Teaching.

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NSBA Leadership Reports, 1991-2
School Health: Helping Children Learn

Price of Report: $15.00. Shipping and handling will be added to billed orders.

FOREWORD

Educators have long recognized a link between health and learning. In the 1990s, the National School Boards Association (NSBA) focuses on the needs of the whole child, a holistic approach to education, and a coordinated youth policy. Just what do these terms mean? They mean we must consider the physical, mental, emotional, and social aspects of the child if we want to ensure learning and achievement in school and develop responsible adults who are productive members of society. They mean we recognize that the unhappy, unhealthy child of today is the parent and citizen of tomorrow. They mean that we need to provide our children with a sense of self-worth, high but reachable expectations, and commitment to community.

NSBA endorses an educational approach that addresses the whole child. NSBA Resolutions encourage local school boards to adopt health education programs that "support the development of students' physical, psychological, and social well-being." NSBA Policy Statements include affirmation of the importance of school district-community participation in programs "that affect all aspects of the child . . ."

In producing this handbook, with the assistance and cooperation of the U.S. Department of Education, NSBA recognizes the difficulties being faced by the education system in meeting the multiple needs of our students. We propose that when these problems are addressed at the local level, our nation's educators will rise to the summons and produce the innovative solutions that are characteristic of American society. This spirit is expressed by a high school principal in Arizona who says, "We don't ask, 'Can we do it?' but 'How can we do it?'"

This challenge has a direct impact on school board members, as each community's education policymakers who provide guidance in the development and implementation of programs, to meet the needs of the whole child. In facing the task of balancing those needs against the school district's responsibility to provide excellent and equitable education in light of the fiscal realities that define our schools' capabilities, there is a tendency to emphasize the most critical issues. It is here that comprehensive school health programs are most valuable. Such programs allow long-range planning, provide a structure for dealing with specific problems as they arise, put single issues into perspective, and reduce the frustration caused by trying to deal with multiple concerns (drug and alcohol abuse, HIV/AIDS, teenage pregnancy, poor academic achievement, poor physical fitness, eating disorders, dropouts, hunger, violence, and more). Comprehensive programs also provide a framework within which school board members and school personnel can attend to what is deemed to be most important at any specific time without losing sight of the overall purpose of providing a good education and improving health and healthy attitudes and behaviors, i.e., linking learning to the needs of the whole child.

NSBA's efforts in this regard have resulted in the formation of the National Consortium to Foster Comprehensive School Health Programs in the Public Schools, and in NSBA's alliances with the National Center for Health Education, The National School Health Education Coalition (NaSHEC), and the National Health/Education Consortium. The collaborative approach exemplified through these ongoing endeavors serves the mutual goals of NSBA and other education and health organizations to link learning and health, and to promote the development of healthy and productive lifestyles for America's future leaders and citizens. To that end, we are pleased to offer this School Leader's Guide, "School Health: Helping Children Learn."

Very Truly Yours,

Arlene R. Penfield
President

Thomas A. Shannon
Executive Director

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PREFACE

During the past two decades, two major trends have affected the responsibility of the public schools in providing health education and services. First, the structure of the family and the demographics of the school-age population have changed dramatically, placing greater burdens for child welfare on school systems. Simply put, families are different now: often, both parents work; there are increasing numbers of single-parent families, especially in our urban and suburban communities; distances between family members have reduced the influence of the extended family on our children; the percentage of minority children in schools continues to grow, resulting in the need to recognize special health needs; and with increasing poverty levels have come increasing health and social service needs of students.

Second, behavior-related chronic diseases have replaced infectious diseases as the leading causes of morbidity and mortality in the United States. Among adolescents and young adults, injuries, homicide, and suicide rank as #1, #2, and #3, respectively, as causes of death, with HIV infection listed as #7. Physical fitness among children and young people continues to decline; for example, today's children have significantly higher levels of body fat than any previous generation. All of these problems come to school with our children.

As elected policymakers governing public education in their communities, many local school boards have acknowledged the responsibility of public schools to promote and provide for the health and well-being of their students. They have established school health programs encompassing health education, health services, and healthy school environments. As a result of the efforts of these educational leaders, several exemplary school health programs exist. However, the overwhelming majority of school districts do not have comprehensive programs.

In large measure, this deficit may be due to the fact that there has been no systematic national effort to collect information about the effective programs currently operating. NSBA concluded that gathering and sharing the planning and implementation experiences of existing programs could be of significant benefit to school board members and other school leaders. Accordingly, NSBA convened the National Consortium to Foster Comprehensive School Health Programs in the Public Schools. The Consortium is composed of representatives of 20 national health and education organizations that have an institutional commitment to student health.

During the past 18 months, the Consortium has identified and assessed approximately 100 school health programs across the country. Programs were nominated for Consortium consideration by school board members, state school boards associations, state education agencies, national education and health organizations, universities, and other interested individuals and agencies. Consortium expertise and a review of the school health literature and research data indicated that there are four broad components of a comprehensive school health program: program philosophy, health instruction, health services, and a healthy school environment. Using these generally accepted components as their guide, the Consortium considered how extensively and effectively the nominated school districts had incorporated or were planning to incorporate these elements into their programs. Establishment of a data bank of school health programs and their components allowed the Consortium to compare and contrast districts according to their special characteristics.

In addition to the compilation of information about school health programs, the Consortium has served as a model for alliances. The cooperative efforts of representatives of the education and health fields in establishing common objectives directed toward a mutually held goal, i.e., fostering comprehensive school health programs in the public schools, furnish ready examples for community alliances. Through their joint undertaking, Consortium members have demonstrated the efficacy of working together to achieve common ends. It is in the spirit of united enterprise that NSBA and the National Consortium present this School Leader's Guide.

Innovative Ways to Meet Needs

Examples of innovative ways in which school districts are addressing the multiple needs of their students are as numerous and varied as are the districts themselves.

In the *Laredo Independent School District, Laredo, Texas*, where the student population is overwhelmingly from low-income families (97 percent receiving free or reduced-cost lunches), special emphasis has been placed on coordination of health services between the school district and community agencies. School personnel are attentive to students' special, and frequently multiple, needs and carefully monitor each child, promoting prevention and ensuring treatment. The general education program is designed to give students a good head start: pre-Kindergarten classes offer computer awareness instruction; and all first graders who have been in Laredo's pre-Kindergarten and Kindergarten classes are able to enter first grade reading. Health instruction is included in pre-Kindergarten, where particular consideration is given to fostering personal health and safety, encompassing abusive and dangerous situations.

The *East Grand School District, Granby, Colorado,* has developed a program aimed at the nutritional needs of its students. "The Training Table" program has been effective in changing eating habits among middle school students, achieving weight losses/gains, and incorporating physical exercise into their daily routines. Program developers have determined that the most significant results have been achieved when parents were involved.

In *Woodburn, Oregon,* the *Woodburn School District* has a high number of English-as-a-second-language students, including nearly 19 percent of the school population who are native Russian speakers and 44 percent who are native Spanish speakers. Many 12- and 13-year-olds enter school for the first time speaking New Mexican Indian dialects as their first language, with Spanish as their second language. Believing that these children need to be exposed to personal health and safety information and practices as soon as possible and as often as possible, teachers use English language courses to present health education. This approach provides an opportunity for more instruction in the limited time of the school day and reinforces both English and health knowledge.

Birmingham, Alabama's Jefferson County School District has established a fund, supplied by monies from the community's Monday Morning Quarterback Club proceeds, to provide dental care for all needy students. Both the school district, which has been conducting the program since the 1950s, and the public health department believe the program has had a positive effect on health and school attendance. An important element of the dental care program is its emphasis on education. Participating dentists and dental care personnel use each contact with students as an opportunity to provide individual attention and instruction intended to promote good dental habits.

"In the great work of education . . . our physical condition, if not the first step in point of importance, is the first in order of time. On the broad and firm foundation of health alone, can the loftiest and most enduring structures of the intellect be reared."

—Horace Mann, *Educator*

CHAPTER I:

OUR CHILDREN'S HEALTH IS OUR FUTURE

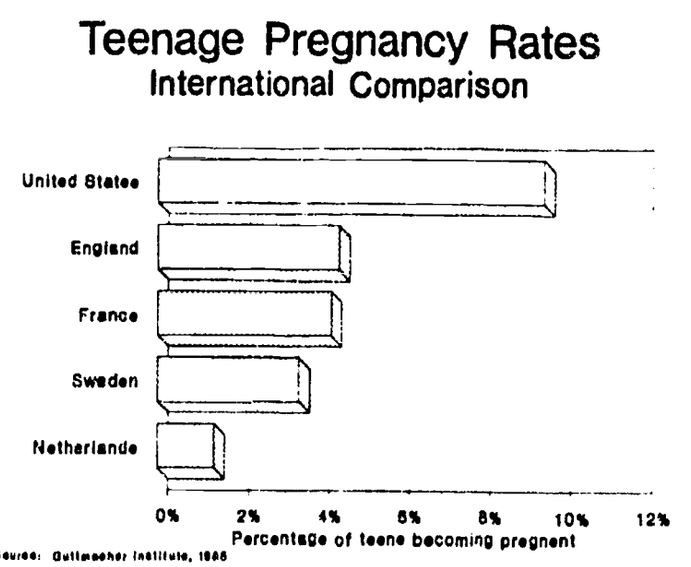
Teenage pregnancy, truancy, academic failure, drunk driving, poor nutrition, depression—all these are just a few of the problems from the laundry list of dilemmas confronting schools and their students. Statistics revealing the numbers of young Americans who consume alcohol, use drugs, get pregnant, drop out of school, and are abused have bombarded us for the past two decades.

Speaking both morally and practically, we cannot ignore the impact of these problems. The Children's Defense Fund makes a strong argument for our need to address them posthaste:

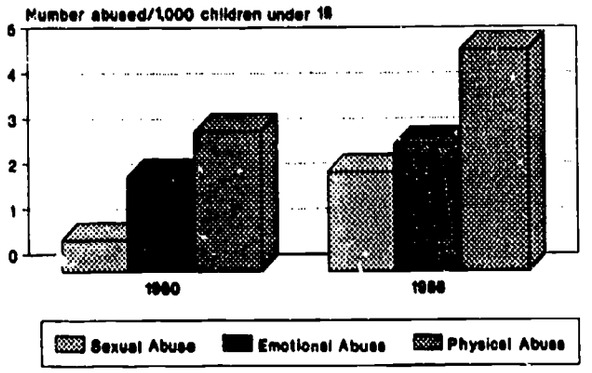
> The number of children—soon to be young adults—in our society is dwindling. In the year 2000, there will be 4.1 million fewer Americans between the ages of 18 and 24 than there were in the mid-1980s. Increased competition abroad means that every one of them must be fully productive. Yet:
>
> - Every eight seconds of the school day, an American child drops out (552,000 during the 1987-88 school year).
> - Every 26 seconds of each day, an American child runs away from home (1.2 million a year).
> - Every 47 seconds, an American child is abused or neglected (675,000 a year).
> - Every 67 seconds, an American teenager has a baby (472,623 in 1987).
> - Every seven minutes, an American child is arrested for a drug offense (76,986 a year).
> - Every 30 minutes, an American child is arrested for drunken driving (17,674 a year).
> - Every 36 minutes, an American child is killed or injured by guns (14,600 a year).
> - Every 53 minutes, an American child dies because of poverty (10,000 a year).
> - Every school day, 135,000 American children bring guns to school. A child is safer in Northern Ireland than on the streets of America.
> - Every day, 100,000 American children are homeless.
>
> The statistics are even worse for poor and minority children, [the] youngsters [who] make up an increasingly large portion of the youth population—and, consequently, of our future work force.
>
> Source: *Children 1990. A Report Card, Briefing Book and Action Primer.* Children's Defense Fund, 1990. pp. 3-5.

Responses to these trends that affect the well-being of our children and our society have been numerous and varied, ranging from suggestions for more proscriptive laws to calls for reinstating traditional family values to teaching decision-making skills in the classroom. Regardless of the problem or the recommended solution, there has been throughout a consistent appeal for educators to take the lead in addressing the physical and emotional health issues that are having a critical impact on our children and their futures.

The public schools do have a responsibility for educating and training the children in our



Rates of Abuse
Among Children and Adolescents



Source: US Dept of Health & Human Services, 1988

communities and for giving them the knowledge and skills necessary for successful living. Educators have accepted this leadership role in confronting societal problems. Of course, the schools alone can neither prevent youngsters from making poor decisions nor correct every inappropriate behavior; nor can they make the political and economic changes necessary to improve our children's well-being.

In order to achieve effective results from any undertaking, a joint effort is required by all the systems influencing a child's life. The most obvious among these are the home, school, peers, health care and social services agencies, religious institutions, law enforcement and judicial systems, civic organizations, business and industry, and the media. In partnership with their communities, schools can provide the framework within which we can turn around the currently devastating statistics.

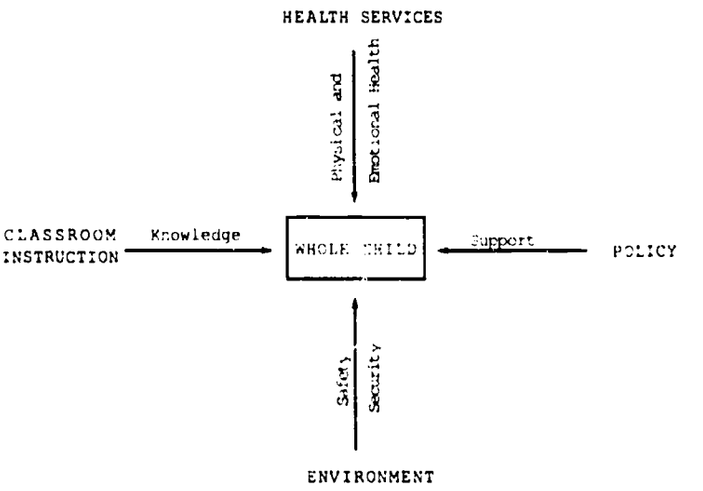
If further impetus is needed, consider two examples offered by the Committee for Economic Development: every $1 spent on immunization programs saves $10 in later medical costs; investing $1 in quality preschool programs pays back $4.75 in terms of lower costs for special education, public assistance, and crime. (1)

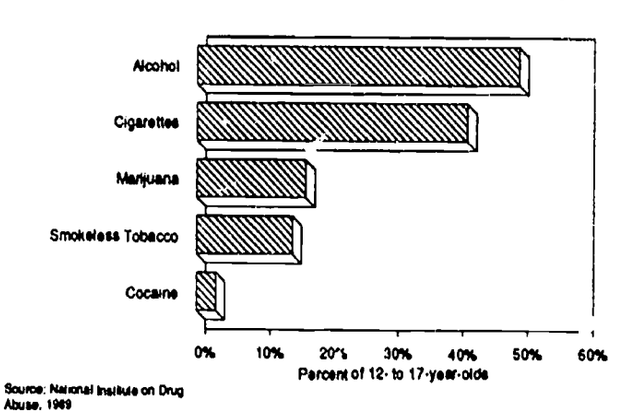
Health education is part of a basic education program that considers the whole child—his or her intellectual capability, physical health, mental and emotional well-being, and social adjustment—and provides him or her with the information and decision-making skills that enable responsible citizenship. In concert with instruction, health services and the establishment of a safe and healthy school environment offer the most efficient means for improving academic achievement opportunities and solving behavior-related health problems: major steps toward meeting our national need for healthier and more productive citizens. Through comprehensive school health programs, we can provide the means for addressing the plethora of health and safety issues that confront school districts—from absenteeism and AIDS to steroid use and suicide. We cannot change the past, but we can shape the future.

Promising Prospects: Comprehensive School Health Programs

What are comprehensive school health programs? They are, first and foremost, "comprehensive": that is, they include health education instruction, health services, and a safe and healthy school environment. Comprehensive school health programs include classroom instruction and school/community activities that encourage development of healthy lifestyles from the beginning of a child's education. They provide information about safety, nutrition, and disease prevention; encourage exercise and physical fitness; teach about physical, mental, and emotional development; discourage use of illegal drugs and tobacco; and help youngsters develop problem-solving and decision-making abilities. They offer the health services of a school nurse and other health professionals, as needed. They provide a safe, healthy, and supportive environment for students and staff.

When provided within the school setting, these three elements (instruction, health services, and environment) involve a broad group of education





and health professionals and agencies from throughout the community. Speaking about the need for coordinated services for children, NSBA Executive Director, Thomas A. Shannon, has said, "[The] holistic approach, marshaling all the public and private resources of a community, is part of the future in a restructured educational 'delivery system.' " (2)

Today's heightened public concern with healthier lifestyles offers the proverbial golden opportunity for improving that delivery system. The significant decline in the use of tobacco and increased interest in nutrition and exercise are just two examples of the public interest in personal and community health. With the opportunity afforded by the current health, fitness, and nutrition craze comes yet another concern: the health of our school children is in a decline. Actor Arnold Schwarzenegger, chairman of the President's Council on Physical Fitness and Sports, has summed up the challenge for us: "[Healthy schools and a] healthy nation start with healthy children." (3)

A Full Plate

The priority attached to healthy living must carry over into the public schools, and with it will come even greater expectations of the education system and its leaders. While the importance afforded health by our national and state leaders and our own intuitive knowledge imply that comprehensive school health programs should assume greater significance, they are but one of the many priorities that local school policymakers must juggle. At no time in history have public examination of the schools been more intense and demands for educational accountability more vociferous. The national education goals promulgated by the President and the nation's governors lay out the ambitious agenda to which local school boards must attend.

National Education Agenda

That by the year 2000,

- all children will start school ready to learn;
- ninety percent of all students will graduate from high school;
- Fourth, eighth, and 12th grade students will be able to demonstrate competency in English, mathematics, science, history, geography, and other designated subjects;
- all students will "learn to use their minds well, so they will be prepared for responsible citizenship, further learning, and productive employment";
- U.S. students will be first in the world in mathematics and science achievement;
- all adults will be literate and have the knowledge and skills necessary to "compete in a global economy and exercise the rights and responsibilities of citizenship"; and,
- every school will be drug-free and violence-free and will provide a "disciplined environment conducive to learning."

To provide the environment in which this ambitious agenda can take place is perhaps the greatest challenge education in America has faced. Florida Governor Lawton Chiles has succinctly phrased our task: "We need to be dealing with the whole child. You're not going to have an educated child until you have a healthy child." (4)

We know that good health is important. We can reasonably assume that teaching skill-based health in our schools will advance good health practices. Research indicates that healthy stu-

dents are better students, i.e., their academic performance is improved. However, despite the acknowledged benefits of health education and the existence of mandates in some states, K through 12 comprehensive health education is provided in relatively few of America's public schools. While health education does exist in some form in most of the nation's 15,376 school districts and 83,165 schools—that is, students are receiving instruction on specific health issues—the quality and scope of that education varies greatly. Estimates concerning the number of comprehensive school health instructional programs in the nation's schools varies from five percent to 14 percent. A 1988 study of comprehensive school health education programs in Michigan, conducted by Michigan State University, reports that classroom teachers were implementing less than 60 percent of the prescribed health lessons. (5)

Obstacles to Opportunity

What is it that stands in the way of implementation of comprehensive school health programs? There are several primary obstacles: directives concerning health education, the already-packed education agenda, the fact that local needs may not be adequately considered, and the impact of coordination with other agencies that provide health education and/or services.

In terms of the directives, school health programs are often planned at national and state levels and then prescribed to the local school systems for implementation. Although planned with good intentions, these programs frequently are not accompanied by the resources needed to execute them. Additionally, there are the present requirements on schools to stress the teaching of mathematics, science, and language skills. "The resulting competition for funds, faculty, and facilities is not likely to favor health teaching. While schools are criticized for their graduates' lack of basic skills because this keeps them from finding jobs, when those same graduates lack ability to handle stress or other health problems, few consider that these skills could have been learned, too. Their lack is just as apparent, as reflected in high rates of absenteeism, poor job performance, alcoholism, and other preventable health problems . . . ." (6)

Inadequate attention to local needs in school health program planning and implementation also can be a significant barrier. It is critical to consider the make-up of existing social and economic factors, community beliefs and standards, and the salient health concerns of community members. Additionally, it is especially important in times of financial crisis to coordinate school health programs with the many health professionals and agencies already established in the community.

Coordination of services is perhaps the most effective and cost-efficient way for schools and community support agencies to meet student needs by reducing duplication, eliminating service gaps, improving overall services, and offering prevention in place of expensive crisis intervention and treatment. NSBA encourages these collaborative efforts and has recently supported introduction of federal legislation to initiate a demonstration grant program to coordinate educational support services for at-risk students. Called "Link-Up for Learning," the program statement notes that "schools are neither professionally nor financially equipped to provide the social services many students need to succeed academically; however, schools are logistically and philosophically the linchpin for coordination of services."

> *"The institutions of public health and education are complementary, and, as such, they must work as partners, sharing their expertise, time, energy, and economic resources if everyone is to realize the potential schools have in contributing to the goal of a healthier citizenry . . . ."*
> —Doctors James Mason and Michael McGinnis, U.S. Department of Health and Human Services' Public Health Service

Overcoming the Obstacles

While recognizing the need to work together to provide quality education and health/social services to our children, we also acknowledge the

existence and magnitude of the obstacles to forming alliances and instituting school health programs. We believe, however, that the obstacles are not beyond our capacity to overcome. NSBA and the National Consortium have prepared this School Leader's Guide to assist in surmounting these barriers in the pathway to providing equal educational opportunities for all our children. This guide for education policymakers and practitioners is intended to provide suggestions and the "how to" information needed in the design and implementation of the comprehensive school health programs that can enhance our prospects for success.

The guide will describe the elements of exemplary programs and illustrate processes for achieving them. Through examples from several existing programs, this handbook will offer guidelines and identify resources for school board members, school administrators and staff, and their communities. It will seek to elucidate the following components of comprehensive school health programs:

- the rationale for school board policies concerning comprehensive health education;
- the planning process, to include involvement of the various education institutions and health agencies and the community;
- development of curricula;
- program implementation steps and aids;
- the role of school health services;
- the school environment;
- program evaluation; and
- resources and support organizations and publications.

"It's not a question of whether we can afford school health, but whether we can afford not to have it."—William Wright, Superintendent of the Apache Junction, Arizona, School District

NSBA and the National Consortium believe that school boards and school administrators are in very significant positions to affect the health and education of the nation's public school students. The quality of the school health program quite literally depends upon the school leaders' perception of its worth and potential consequences. When school board and administrative commitment is strong, it is much more likely that solid community support will follow, enabling the development and implementation of an effective program. Public schools and their leaders currently hold what may be a position of all-time importance in our history as the social institution most able to address and influence the knowledge and behaviors that will result in healthy and productive lifestyles for American citizens. ■

Losses

In 1987:

603 million work days were lost to illness or disability*;

337,928 clients were enrolled in alcohol treatment programs+;

260,151 clients were enrolled in drug abuse treatment+.

School days lost due to illness or injury totalled 198 million in the U.S., 4.4 days for every public school student in grades K-12.◆

Education Costs

$20,000 a year supports an 18-year-old, either in prison or at Stanford University.▲

$15,000 a year is needed to educate a child born addicted to drugs.▲

$9,000 is the average yearly cost of educating a child with "ordinary special education" needs.▲

$3,000 is the average yearly education price tag for a healthy child.▲

Sources:
* National Center for Health Statistics
+ National Institute on Drug Abuse
◆ U.S. Department of Commerce, Bureau of the Census, 1990
▲ National Health/Education Consortium

CHAPTER II

FIRST THINGS FIRST

Healthy students have been an educational concern for generations. In 1916, John Dewey urged schools to provide school health programs, saying, "Make health an aim." Dewey's charge remains valid in the 1990s. Among the compelling reasons for developing school health programs, the following two speak most directly of the exigency:

1) Many of the threatening health problems confronting the nation's children and young people are those that can be controlled by personal decisions and behaviors.
2) The health attitudes and behaviors that develop during childhood are likely to be the ones sustained through adulthood. After the home, schools are probably best suited and most effective in providing health education to students, an important element of which is development of the thinking and decision-making skills that can affect life-long behavior.

their primary goal: offering a quality education to all public school students.

The Basic Parts

There are four basic components for comprehensive school health programs, each of which complements and is complemented by the others.

1. School Health Program Philosophy and Goals
2. School Health Instruction
3. School Health Services
4. Healthy School Environment

☑ *School Health Program Philosophy and Goals*

Comprehensive school health programs begin with a statement of the school board's attitudes and expectations concerning the program. The philosophy of the board pertaining to school health—its importance in the overall education agenda and its relation to the district's general education objectives—sets the tone for program development and implementation. There is perhaps no more critical element in the planning and successful implementation of comprehensive school health programs than the school board's

Leading Causes of Death

10 Leading Causes of Death for Children, Ages 1-14 (1989)

1. Injuries, approximately half involving motor vehicles
2. Cancer
3. Congenital anomalies
4. Homicide
5. Heart disease
6. Pneumonia/Influenza
7. Suicide
8. Meningitis
9. Chronic lung disease
10. HIV infection

Source: National Center For Health Statistics.

10 Leading Causes of Death for Youth, Ages 15-24 (1987)

1. Injuries, three-fourths of which involve motor vehicles
2. Homicide
3. Suicide
4. Cancer
5. Heart disease
6. Congenital anomalies
7. HIV infection
8. Pneumonia/Influenza
9. Stroke
10. Chronic lung disease

Source: *Monthly Vital Statistics Report*, Sept. 1989.

Concern for the future and for the immediate educational and health needs of our children and our communities has roused school boards to meet the challenge. Comprehensive school health programs provide a means for school boards to achieve

policies and resultant practiceswhich derive from the philosophy underlying the program. Strong school board commitment, as expressed in its philosophy and goals, can result in better planning on the part of the administration, clearer understanding and, thereby, more likely support from parents and the general community, and greater investment of time and effort by teachers and other staff members. To use terminology from management theory, the school board directive provides the structure and support base for programs.

School board members, as education policymakers, know that the formation and adoption of mission statements is but the beginning of the policy development process. Once the philosophy is established, goals need to be determined

Philosophies

The Statement of Philosophy concerning comprehensive school health programs from the *Montpelier Public School District in Montpelier, North Dakota*, stresses the program's importance within the district's general education plan.

> Health is defined as the state of complete mental, physical, emotional, and social well-being, not just the absence of disease or infirmity. In addition, wellness is defined as the positive, healthy lifestyle one chooses in order to achieve his or her highest potential for well-being. We believe, to achieve that potential, students must be given accurate, clearly defined and current health knowledge. We further believe that knowledge, alone, will not guarantee practice of healthy lifestyles. Therefore, the Montpelier school health education program begins at the very earliest age with the building of positive self concepts and decision-making techniques.
>
> Young people today are facing increased pressure from many different directions, including the threat of AIDS, drug and alcohol abuse, peer pressure for earlier premarital sex, family instability, and environmental pollution. We believe that their future well-being will depend heavily on the skills and attitudes that we give them during their school years. . . . We feel this program must be given high priority in the use of time and resources of this district.

The *Collingswood School District, Collingswood, New Jersey*, has addressed health education for special education students in an addendum to their special education philosophy.

> Health Education classes provide an ideal opportunity for mainstreaming Special Education pupils. For these students, the accompanying course of study will be modified through varying techniques, strategies, materials, etc., and individually reflected in the student's IEP (Individual Education Program). A modified program is also available for students who require specialized attention to one or more of these activity areas.

In a comprehensive statement of their school health program philosophy, the *Lincoln County School District in Newport, Oregon*, has included several program elements, including:

> Health is based on the quality of life of the whole person (i.e., spiritual, intellectual, emotional, physical, and social). The holistic health concept suggests that all elements of an individual must be considered before optimum health can exist. For example, good nutrition must be accompanied by fitness activities, safety strategies, and mental health considerations in order to achieve a decent quality of life.
>
> The quality of health education is directly related to the commitment of the superintendent and the school board. Students, teachers, parents, and health professionals need to be a part of the development [of a school health program].

In the rationale for its school health programs, *Parkway School District in Chesterfield, Missouri*, has said:

> The primary function of a school is to provide students with the learning experience necessary toward development of their maximum intellectual capacity. The success of this process is limited by the child's emotional, social, and physical health. For this reason the purpose of a comprehensive health education program is twofold: First, to consider the total human being in the educational process, and second, to motivate students to help themselves and others to live healthy, productive lives.

and then reinforced with specific policies. In determining the program goals that will drive policy development, each school board must assess the desires and needs of its own community in terms of what should be taught by and result from the health instruction component of the program, what school health services should be provided, and what the school health environment should encompass.

☑ *Health Instruction*

Health Instruction, as a framework for comprehensive school health programs, should reflect the program's general goals. Goals for student learning and outcomes should include:

- providing students with the knowledge and skills that enable them to adopt and maintain healthy attitudes and behaviors throughout their lives;
- developing student abilities to gather, assess, and use information to make appropriate health-related decisions; and
- addressing the needs of all students, regardless of ability, including those with learning-related handicaps and those who are disadvantaged because of language, socioeconomic, or environmental conditions.

Curriculum should offer sequential health instruction for grades K through 12 that reflects current health issues focusing on the special needs of the local community.

A vital part of instruction is staff development. Training goals should include:

- teacher and health services staff involvement in curriculum planning, curriculum development, and program implementation; and
- appropriate inservice training to provide teachers and other staff members with the information and strategies needed for teaching and supporting the new curriculum and dealing with the inevitable changes that occur in meeting health education needs

☑ *Health Services*

Health services goals need to include the establishment of appropriate school-based and referred health services that reflect the educational and community commitment to address the identified health problems that limit student abilities to learn; involvement of health services personnel in program development and training; and coordination of school-based and community health services. Health services personnel (school nurses, counselors, community health care providers) should be involved in instruction and the promotion as well as provision of a healthy school environment.

☑ *A Healthy School Environment*

A healthy school environment should include caring for physical facilities and stressing the importance of positive mental health and emotional climates within the school setting, both of which enable children to learn better and enhance the quality of their lives while in school and in the future. This includes, among its many elements, ensuring the physical safety of the students and staff, attending to food services, assessing the focus of the physical education program, and developing positive interpersonal relationships among staff members and between school staff and students. Since the school also serves as a worksite, staff health and well-being need to be a basic consideration in developing comprehensive school health programs. In addition to the benefits directly attained from a healthier school staff, these adults are important role models for student health.

Establishing the Goals

Building on its Statement of Philosophy, the *Lincoln County School District, Newport, Oregon*, has stated its school health program goals within the context of the district's Education Goals (Policy 6100):

> The Lincoln County School District is committed to striving for the fulfillment of each individual's maximum potential by providing programs and environments that will enable students to:
>
> - develop skills and attitudes to deal with change, make decisions, and assume responsibilities for life's roles;
> - develop the skills to function cooperatively and to respect the rights of individuals; and

Healthy Environment

As part of providing a healthy school environment, the *Cimarron Municipal School District in New Mexico* is dealing with the nutritional concerns of their students and community in innovative ways. Because of the school schedule of four days per week with increased hours per school day, the school provides elementary students with a free, healthy midafternoon snack. Fruit juices, milk, fruit, nuts, and cheeses are some of the foods that are distributed to the children. The cost of the program, which is funded through the general school budget, is estimated at $.50 per child with an average of 300 children participating daily.

The district's food service program, servicing a 42 percent Hispanic student population, offers many ethnic food choices in its menus and encourages the community to participate in the program by inviting parents to come and eat lunch with their children.

District teachers also provide workshops on healthy cooking to parents. The focus of the workshops is the preparation of traditional foods in a healthy manner by reducing fat and salt contents. These workshops, along with other fitness tips disseminated through school newsletters, are partially funded through a grant from the New Mexico Department of Education.

- develop knowledge and skills necessary for mental and physical well-being.

Additionally, the district has adopted the State of Oregon Health Education Goals which include safe living behaviors, management of stress and/or risk-taking behaviors, physical fitness behaviors, and appropriate eating behaviors. These goals are identified as part of the "key concepts enabling the acquisition of skills necessary to live a healthful life and to value improved health status as a national goal."

In the *Westlake City School District, Westlake, Ohio*, the school health program goals include the following:

- to help each individual acquire, to the best of his or her ability, good physical and mental health habits as well as an understanding of physical, moral, and emotional well-being; and
- to provide an educational environment and support services that are safe, effective, and efficient.

An important part of the goals statement is recognition of the need for community involvement. The shared responsibilities of the school district and the local community may be reflected in the following ways:

- a statement of an understanding of the necessity for school leadership in, and primary responsibility for, providing comprehensive school health programs;
- recognition that schools do not exist in isolation from the community and that learning is not limited to the school environment, since much of what is learned is affected by influences outside the classroom, and that adoption and maintenance of healthy behaviors is increased if the messages from multiple sources are consistent;
- acknowledgement of the shared responsibility for student health with the home, public and private health care systems, law enforcement and justice systems, government, environmental agencies, business, religious organizations and civic groups, and the media; and
- appreciation of the increased effectiveness to be gained from joint community efforts, in terms of eliminating gaps and overlaps and approaching solutions in a coordinated manner.

The significance of providing school board direction and support in developing comprehensive school health programs cannot be overstated. Well-conceived statements of program philosophy and goals, and the resulting policies, to which many persons have contributed, give the school system tangible authority in implementing desired programs.

School board commitment is critical to health as a central concern in providing quality education and to health education as a responsibility of the school district; to administrative leadership

for program development and implementation, as guided by board policy; and to provision of sufficient resources, including instructional materials, time, teachers and support staff, and training.

Knowing that the school board is behind them, teachers and administrators are more likely to initiate and expand programs that energize the entire educational process.

Beyond the Goals: Policy Development

There is a need for expediency in addressing the multiple health concerns that impact on our schools and their abilities to meet the goal of providing quality education to all students—a need arising from concerns ranging from the undernourished child to the AIDS epidemic. The ultimate responsibility for school health education rests with school boards. As the locally elected or appointed education policymakers, board members must ensure that education programs meet community needs, reflect community values, and are designed and implemented appropriately.

As previously noted, perhaps the most decisive element in the development and achievement of any education program is the school board's supporting goals and policies. Many school boards do not have a specific policy concerning comprehensive school health programs because they believe that the necessary guidelines are covered within existing general education philosophy and goals statements. However, those current policies do need to be reviewed to determine their applicability. If the school board concludes that the relevant issues, such as curriculum adoption and review, inservice training, health services, and program evaluation, are covered by already adopted policies, it becomes important that parents, teachers, and the community understand that a comprehensive school health program will be planned and implemented according to the established policies.

NSBA's National Education Policy Network (NEPN), a codified system for policy development and management, suggests several topics that relate to school health policy development. While not all-inclusive, the following list demonstrates the scope of issues that fall within a comprehensive school health program. Policies to be considered/revised might include:

- Health education advisory committee
- Health program budget planning
- Safety and accident prevention programs
- Building and grounds inspection
- School food services
- Staff health and safety
- Smoking on school premises by students and staff
- Health education curriculum and instruction
- Teaching about drugs, alcohol and tobacco
- Family life education
- Health services

The physical and mental well-being of students is a prerequisite for achieving our educational objectives."—William Honig, California Superintendent of Public Instruction

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Some school districts have chosen to state their position on comprehensive school health programs in a separate policy. Development of a specific policy concerning school health programs has a number of advantages. It serves to:

- convey to the school community district commitment to comprehensive school health programs;
- diminish concerns that health education or school health services will occur in a fragmented or transitory manner;
- designate that programs be integrated into the curriculum requirements of the school district, that appropriate information be presented in a sequential manner, and that all elements of a comprehensive program be addressed;
- provide guidance to school district staff on program development, planning, and implementation, and assure them of board support; and

- involve parents and community members in planning, and assure them that they have an option for having their children excused from any part of the program if they do not want them to participate.

Whether a school board decides to adopt a separate policy or to include comprehensive school health programs in existing policies, the impact is the board's public statement to the community that good health and effective education are inescapably intertwined, and that the board's objective is to ensure the successful educational achievement of all students. ■

Policy Examples

Wichita

The *Wichita, Kansas, School Board* has adopted youth services policies which provide the framework for the district's school health program. Two of those policies address the relationship between health services and instruction, and health services and the school environment.

> The Health Services staff will aid pupils in developing positive health attitudes and in understanding their physical, mental, and social health through health education.

Administrative Implemental Procedures:

1. The school nurses will use health counseling as an indirect approach to health education.
2. When requested, school nurses will prepare and present health lessons in classrooms.
3. The school nurses will serve as health education resource persons in assigned schools, and they will work cooperatively with personnel in the Curriculum Services Division in program implementation.

> Environment in school living has its impact upon the physical, mental, and social well-being of pupils and as such is, in part, a responsibility of the Health Services Staff.

Administrative Implemental Procedures:

1. School nurses will be sensitive to the school environment and work toward the preservation and cultivation of a healthful, wholesome, and humanizing school environment.
2. School nurses will be aware of the individual needs of pupils and serve as their health advocate.
3. School nurses will be aware of the principles of maintaining a safe, attractive, and hygienic school environment, and work with the principals toward these goals.

Arlington Heights

Addressing the need to provide an effective school health program, the *Arlington Heights, Illinois, School Board* has incorporated accountability for health instruction in policies:

An effective school health program needs to include a system for "student accountability." In order to address this need, the school board of Township Heights School District #214, located in Arlington Heights, Illinois, approved the following policies:

> Health will receive a letter grade, as well as 1/2 unit of credit per semester. The grade is included in student's grade point average, and is required for all students. High School graduation requirements were changed to reflect the inclusion of health in the student's GPA. This policy took effect in September, 1989.

Big Rapids

School health policy in *Big Rapids, Michigan*, includes the following requirements for health and physical education, and substance abuse education:

Health and Physical Education

> Health and physical education curricula will be appropriate to the participating students relative to their physical condition, age, acquired skills, and previous instruction. Health records will be maintained for use by the professional staff in developing appropriate health instruction for individuals and in assigning students to physical education programs.
>
> Students with physical handicaps will be assigned programs of physical education for (1) unlimited activity, (2) modified activity, or (3)

Policy Examples, Continued

restricted activity. The school will at all times endeavor to provide the kind of physical education program suited to the students' needs. Temporary modifications, such as those needed by a student recuperating from illness, will be made provided the student presents an excuse from a physician. A student must participate in an appropriate physical education program in order to graduate unless the requirement is waived by the Board for justifiable reason.

Teaching About Drugs, Alcohol, and Tobacco

Michigan law requires, and the Board of Education firmly supports, instruction in the abusive use of tobacco, alcohol, and drugs and their effect upon the human system. The objectives of the substance abuse curriculum are based on the belief that prevention requires education and that the most important aspect of the program should be the education of each individual student to the dangers of drug abuse.

The drug education program shall be conducted as an integral part of the health education program in the elementary grades and incorporated into other relevant subject areas in the secondary grades. The program shall be organized sequentially and shall be comprehensive in scope. . . .

Greenacres

School Board policies in *Central Valley School District Number 356, Greenacres, Washington,* concerning instruction state:

Human Growth and Development shall be taught in the classrooms of the District as an integral part of the regular course of study in grades K through 12. These concepts shall be integrated into the instructional program as appropriate to grade level and course of study. . . .

The District believes the purpose of Human Growth and Development education is to serve as a resource, to encourage communication between parents and students, and to help students acquire factual knowledge, skills, attitudes, and values which shall result in behavior that contributes to the well-being of the individual, the family, and society. The District recognizes that parents have the primary responsibility for the education of children in the area of human sexuality.

Any parent/guardian/custodian who wishes to have his or her child excused from any planned instruction in the anatomy and physiology of human reproduction or human sexuality may do so upon filing a written request with the building principal. Alternative educational endeavors shall be provided for those so excused, and the student's grade and credit shall not be adversely affected.

The District shall involve parents and school district community groups in the planning, development, evaluation, and revision of any instruction of the anatomy and physiology of human reproduction and human sexuality offered as a part of the school program.

CHAPTER III

ORGANIZING FOR SUCCESS

Having put into writing its program philosophy and goals and examined the existing/needed policies, school boards will want to take a closer look at the program planning and implementation procedures that will determine the scope of final board policies.

In this chapter, we will review that process, consider the program components that impact on it, and see what some successful school health programs are doing.

When we talk about health education, we first think of the curriculum and classroom instruction components of school health programs. However, providing information alone will not change behavior. If it would, no adult would smoke or be overweight. Demonstrating this fact, the results of a 1987 study of sexually active young people in San Francisco (reported in the *American Journal of Public Health* in April, 1988) showed that knowledge about the potentially hazardous consequences of sexual intercourse did not effectively alter adolescent behavior. Having received school-based sex education and having been exposed to numerous public health media messages, the adolescents in this study reported that they were aware that condoms reduce the risk of sexually transmitted diseases. Nevertheless, these San Francisco youth continued to have sexual intercourse with multiple partners and did not substantially increase their use of condoms. (7)

"Health Education is designed to help the students realize that the body is their greatest natural resource in life, that the body is uniquely their own, that it is exquisitely beautiful and complex in its structure and functions, that it is influenced by their own choices made throughout life, and that it has the potential of bringing experiences in life more exciting than anything imaginable because they will be their own experiences."
—Dean Austin, Consultant for Health Education and Physical Education, Lincoln, Nebraska

Educators and public health officials point to studies like this one, not in desperation, but to illustrate the necessity of comprehensive school health programs that are based on an understanding of their target audiences—young people who typically have difficulty in accepting the relationship between present behaviors and future risks. Programs also need to be multifaceted, including skill-based instruction, health services, and a healthy school environment. A most hopeful note is that many comprehensive school health programs, some of which are highlighted in this guide, have been successful in changing harmful behaviors, i.e., reducing smoking, increasing physical fitness, reducing teenage pregnancy, and even improving academic achievement.

It is time for school boards to be proactive leaders in:

- linking up school and community health and social services, emphasizing prevention and early intervention for the problems that impact on students' abilities to learn;
- encouraging parental involvement in schools, stressing the parents' role as the primary teachers;
- providing the instructional programs, health services, and environments that expand knowledge and develop the attitudes and behaviors that enable students to succeed

School Health Program Results

FARGO: Reduced Smoking

In cooperation with the University of Minnesota, the *Fargo, North Dakota, Public Schools* have been involved in a 10-year federally-funded program called the Minnesota Heart Health Project, aimed at reducing cardiovascular disease by modifying risky behaviors and investigating the effectiveness of comprehensive health education on school-aged children. Part of the program was a six-session smoking prevention program called "Keep it Clean," which emphasized the negative immediate consequences of smoking and provided social skills to resist influences to start smoking. This project, implemented at the seventh grade level, was presented by trained peer leaders who communicated the anti-smoking message to small group health classes. The anti-smoking message was reinforced through supporting activities, community supported programs to promote healthy behavior, and implementation of a health curriculum that re-emphasized the anti-smoking message. The students were surveyed each year of the program to ascertain rates of smoking, number of cigarettes smoked, behavioral attitudes toward smoking, and effects of peer influence on smoking behavior. The effectiveness of this program was observed in a controlled study: Tenth grade Fargo students were found to have a 65 percent lower risk of smoking than students of similar age in the control group of students in a demographically and geographically similar community. By 1989, five years after the original curriculum was presented to the students, the risk of smoking among the 12th grade students who had participated in the "Keep It Clean" curriculum and supporting activities was approximately half of that of the students in the control group.

FAYETTE COUNTY: Academic Achievement

A common concern voiced about the implementation of comprehensive school health programs is the already limited amount of time available in the school day. This is especially problematic when the time devoted to health education cuts into some of the "core" courses in the curriculum. *Fayette County School Corporation in Connersville, Indiana*, faced these concerns when it began implementing health education into some of its district schools, integrating it with the science curriculum. In order to ascertain the effect of the diversion of time from science instruction to health instruction, the district compared science scores from the districtwide standardized science tests administered at the fourth and fifth grade levels. To the surprise of the teachers and administrators, the children in schools that had instituted health education curriculum actually did better on the standardized science test than those children whose schools had not diverted time from the science curriculum for health education.

Integrated Science-Health Curriculum

Year	Grade	Schools With	Schools Without
1988	4th	48.3	46.7
	5th	51.9	51.6
1989	4th	50.2	49.2
	5th	53.0	52.0
1990	4th	53.1	50.3
	5th	55.6	53.1

Although many factors could have contributed to the results, it seems clear that the diversion of time from the science curriculum did not lessen the children's understanding of the required science concepts, and it may actually have helped. Although Ms. Arlene Bliven, Director of Curriculum in the Fayette County School District, cautioned against drawing any conclusions from such a limited sample group, she felt that the interactive nature of the health curriculum may have been a contributing factor.

And More Results:

The *School District of Suffield, Connecticut,* uses a series of pre- and post-testing and surveys to determine the effectiveness of their health program on knowledge and behavioral changes. They report that these instruments show continuing improvement in behavior patterns, especially in the areas of improved communication between the district's youth and local police and a decrease in substance abuse.

Montpelier Public School District #14 in North Dakota is beginning to see results from its health program, too. Students are making healthier food selections, noticeable weight loss is occurring among students and staff alike, and community participation in district-sponsored health activities is on the upswing.

Community statistics and general observation are convincing the *Dubuque Community School District* in *Iowa* that a comprehensive school health program makes a difference. Decreases in adolescent pregnancy rates and decreased incidence of drug abuse among the district youth are just two of the positive effects. Older students are "speaking out" for health and providing healthy models for the younger students. The district is planning a more formal review of the program in 1991 to provide hard data of the effectiveness of the program.

With funds from a Wisconsin Department of Education grant, the *Pewaukee, Wisconsin, Public Schools* conducted a self-assessment survey of their seventh grade students. Through pre- and post-testing, they found that the students completing a year's health curriculum increased their self-esteem level by an average of 10 percent. This district also reports a decrease in the adolescent pregnancy rates and a PRIDE survey indicates a 20 percent decrease in alcohol use by Pewaukee seniors for the years 1987-1990.

Though these reports are, for the most part, not supported by scientific data, they are nevertheless important indicators of the positive effects of comprehensive health programs in our schools. With the implementation of these programs, administrators, teachers, and school board members are reporting positive changes in student behaviors—one of the main goals of school health programs.

academically and in their future endeavors:

- meeting the physical, mental, emotional, and social needs of today's children in order to prepare them to be tomorrow's happy, healthy, and productive adults:
- in short, removing the barriers to learning and development for public school students and providing the opportunity for a better future for our children and, hence, our nation.

The means is at hand: Comprehensive School Health Programs. Let us begin.

The First Steps: Program Planning—Who Will Do It?

Because of the importance of school health and the breadth of issues involved, an early consideration in planning is that of the position of program coordinator. Management of the various components of a comprehensive school health program and its successful integration into the total education program deserves, even demands, the attention of a central person. A school health program coordinator is key to effective program development and implementation.

Programs highlighted in this handbook have in common the designation of a person to coordinate the programs. The amount of time that each coordinator devotes to the school health program varies greatly, from 10 percent to 100 percent. It is not so much the amount of time spent as it is the interest and organizational abilities of the one person designated to coordinate and supervise the program. A coordinator should be responsible for assuring timely development and implementation of the various program elements (instruction, health services, environmental aspects) and effectively unifying the components. He or she must also be an enthusiastic supporter of comprehensive school health programs, convincing others in the community of the importance of school health. The program coordinator also needs to be someone

who can gain support, mobilize people, develop funding sources, anticipate problems, and develop solutions; someone who acts as a role model for students and staff; and someone who is an energetic, dedicated, innovative person. The coordinator is the "someone" who needs to ensure that the classroom curricula, the health services, the food services, staff wellness, inservice training for health teachers, student safety, and all the elements of a school health program add up to a comprehensive program.

If this were not enough, a program coordinator is needed to identify and organize resources, evaluate program effectiveness, plan for future needs, and work with the school advisory committee and local health representatives.

Perhaps the best description of a school health program coordinator is the following, adapted from a sample classified advertisement for educators:

> *Wanted:* Progressive (school health program coordinator) with good listening skills. Challenging opportunities to facilitate the learning and development of hundreds of students, faculty, and staff daily. Believes that schools can play a vital role in health promotion. Believes that schools have a responsibility to emphasize the development of lifestyles that promote health. Agrees that health and learning ability are interrelated. Supports the concept that health education early in life can help to prevent many problems in youth and diseases of adulthood, and thus contributes to improving the quality of life for the individual, family, and community. The desired candidate will be convinced or potentially educable that health education is truly one of the basics of a quality education. The candidate selected should perceive teaching and learning as more than a transfer of information from one person to another and agree that the process and goals of instruction involve critical thinking and problem-solving skills. Excellent communication and leadership skills required . . . . Special nature of work often precludes fringe benefits. Salary not necessarily commensurate with effort and responsibilities. Strong belief in values of nonpecuniary aspects of work. (8)

Involving the Community

The importance of inviting community participation and actively working with all segments of the community cannot be overstated in the development of comprehensive school health programs. It is increasingly obvious that isolated attempts to solve a problem are not effective; the "team" approach should be our aim. Schools do not exist in isolation from the community that sanctions and supports education with its time and tax dollars, nor does learning occur only in school. In addition, many influencing factors in students' lives are outside the school's province. Schools must, therefore, form partnerships with parents and the community in order to provide effective school health programs. As representatives of their communities, school board members are particularly sensitive to these issues and the need to ensure optimal support of education programs, as well as to verify that the programs are meeting local needs and desires.

It is increasingly obvious that isolated attempts to solve a problem are not effective; the "team" approach should be our aim.

School board members, as the chief education policymakers at the local level, are the community's education leaders. As leaders, they must surpass the ever-present need to appeal for more resources; they must also provide the vision and the inspiration to ensure continuing improvement in educational quality and in meeting the needs of all students. To that end, 1990-91 NSBA President, Martha C. Fricke, called a national meeting of local community leaders in February 1991 to discuss collaboration of services for children. Hosted by the Johnson Foundation at the Wingspread Conference Center (Racine, Wisconsin), the conference objectives were:

Community Involvement

The *Springdale, Arkansas, School District* has extensively utilized the community resources available to them to strengthen their school health program. Through cooperative efforts with the community, the school district has been able to offer a variety of otherwise unavailable services and educational opportunities to the students. Through task forces made up of local organizations, in cooperation with the University of Arkansas, and through personal contacts between school officials and the larger community, the school district has tapped local resources to offer several programs to school students and staff, including: blood sugar and cholesterol screening, provided by local hospital staff, for a $5.00 fee to high school students with parental permission and to the entire Springdale Public School community; the FATE program (Fighting AIDS Through Education), taught to high school students by a group of medical students from the University of Arkansas for Medical Sciences; a program presented by speakers from the Economic Opportunity Agency that examines the financial costs of teen pregnancy; smoking cessation clinics offered through the local hospital; and programs that provide alternate means of transportation at no charge and with no questions asked, sponsored by the local business community to ensure that youths do not drive drunk. By incorporating the community resources available in a partnership with the local leaders, the school district has forged an innovative approach to school health with the limited budget available.

The *Plymouth and Plymouth-Carver Regional School District* in *Massachusetts* has created several truly effective supporting activities which act to reinforce the messages communicated in the educational component of their comprehensive school health program. One of the district's health educators initiated a program to intervene early in situations with students exhibiting problem behaviors. Through this student assistance program, called the STAR Process, school staff members are trained to identify behaviors that may indicate deeper problems. Acting on referrals from teachers and/or other staff members, the STAR Team, including the principal, health educator, school psychologist, school adjustment counselor, guidance counselor, and school nurse, reviews and assesses the information and takes appropriate action. This may include school counseling services or referral services to outside health providers. The integrated staff approach helps in addressing the problems of the whole child rather than dealing with just one specific behavioral problem. Though the STAR Process is only in its first year, team members report that this process is proving to be successful.

The Plymouth Saving Lives Program is a privately funded program designed to increase passenger safety. It focuses on peer education, parent education, and extensive student-community interaction through Community Awareness Days and Health and Fitness Fairs. The district's curriculum includes seat belt usage and driving safety, reinforcing the Saving Lives message.

Plymouth-Carver also has established a close relationship with the Plymouth Rotary to sponsor a Drug and Alcohol Free For Ever (D.A.F.F.E.) Walk in which students, teachers, parents, and other community members walk to raise money for community drug education. In addition, the district draws on the community for help in providing speakers, including representatives from the Rape Crisis Center, Occupational Safety and Health Administration (OSHA), Department of Public Health, and members of the business community.

Taken together, these programs and community resources combine to make a powerful activities component to the district's comprehensive school health program.

Barbara Wallace, Chair of the *Lee County School Board, Ft. Myer, Florida,* attributes the development and implementation of the district's comprehensive school health program to the efforts of program coordinator, Dr. Elizabeth Harmon. Ms. Wallace says, "Our success in implementing a good comprehensive school health program and in continuing to plan for the future needs of our children is the result of [Dr. Harmon's] dedication to promoting school health and her insistence on early and ongoing community involvement." Measures of the success of Lee County's program include strong school board support for expanding health education and services, increasing awareness of the need for the program in the culturally diverse and changing county (the fastest growing county in the country), and continuing broad community involvement in the program.

- to develop a joint policy statement advocating a holistic approach by community agencies that addresses the needs of children and youth; and

- to recommend strategies that can be implemented at the local level to advance cooperative efforts.

Such undertakings, in which community leaders can share their common problems and, together, find common solutions, are the cornerstone of successful programs that can begin to meet the needs of the whole child.

Many school districts have recognized the significance of community involvement and the value of public information campaigns in helping to implement school health programs, especially some of the more controversial issues within the health curriculum, such as HIV/AIDS education or family life components. Some districts hold open meetings to answer questions and address community concerns; some send information concerning curriculum content to parents; some provide instructional materials and videotapes for preview. All of these school districts have included community members in planning and developing holistic programs that foster collaboration, rather than competition, in serving students and their families. They seek to avoid what syndicated columnist William Raspberry has described as a confusing variety of disconnected agencies scattered throughout the community, by combining resources and efforts. ("'What It Takes' to Deliver Social Services," *The Washington Post* op-ed, 1/30/91).

These school districts have noted several results from their efforts:

- Parents and other citizens have learned that a comprehensive school health program will not teach anything that would contradict community values.

- Parents and others feel that they have contributed to the program and have more interest in its success.

Checklist for Building a School-Community Partnership

1. Determine needs and concerns of the school community regarding student health problems from sampling of public opinion (polls, school board meetings, and other open forums); surveys to parents, students, teachers, community members; and data concerning local health services and needs.

2. Assess the current school health program and its effectiveness in addressing needs and concerns identified by the community.

3. Plan a public information campaign to provide the community with the results of the needs assessment and to solicit community input into planning a responsive school health program, perhaps through school newsletters, the local news media, and/or public meetings.

4. Involve parents and community organizations:

   a. Identify individuals and agencies with leadership roles in the community and with professional and/or personal commitments to health and education.
   b. Stress the need for and advantages of collaborative efforts in serving the whole child to assure optimal physical, emotional, intellectual, and social development.

5. Develop means for expanding and maintaining community awareness using:

   - regular communication through newsletters
   - periodic information concerning specific activities or occurrences
   - availability of instructional materials for parental review
   - school-community activities involving parents and the community at large

6. Plan for a continuing communications process. Like a marriage, a long-lasting school-community partnership needs constant attention and open communication.

Advisory Committee

The inclusion of different members of the community in the process of developing a comprehensive school health program can ensure that problems of particular concern to the community are addressed in a way that has the support of everyone involved.

The *Binghamton, New York, School District's Advisory Board* is an example of a multifaceted community group. It includes public health officials, who can ensure that the correct health information is being taught; teachers, whose involvement can ensure that the material will be taught; parents, who provide the direct link to the home ensuring that healthy behavior continues outside the school; students, who can ensure that the concerns of the student body are addressed; and religious and community-based organizations, which can communicate the concerns of the community, ensuring that health education is compatible with the larger community. These representatives of Binghamton come together to help develop a health curriculum, health services, and a safe school environment which best serve their student body. This voluntary board also serves as the state mandated advisory body on AIDS education. By combining the advisory function mandated for certain aspects of health education with the overall health education curriculum, this board creates the comprehensive approach toward health education which is needed, rather than a fragmented approach which can easily result from disparate approaches. Finally, by including all the members of the community who have an interest in school health issues on the committee, the school district can allay concerns raised regarding often controversial subjects, such as family life and HIV/AIDS education.

- Community members express assurance in the knowledge that their school board and school staffs are accountable to them in providing the best possible education to their students.

- Community agencies report greater visibility and credibility within the community; savings in time, money, and effort brought about by reducing duplicated services; increased quantity and quality of services; higher public understanding of problems; more effective and efficient use of existing resources; and the mobilization of additional resources.

The Structure of a Partnership: The School Health Advisory Committee

In order to assure maintenance of a working partnership, a defined association of the persons involved in a comprehensive delivery system is recommended. School health advisory committees, composed of interested and informed community members, can provide the structure and the mechanisms necessary to coordinate existing services and expand them to meet identified needs. School districts with operating advisory committees have deemed them essential to the promotion and continuation of school health programs.

The benefits gained from school-parent-community partnerships are numerous and mutual. For the school district, we have seen increased financial support for school health and other programs, backing for controversial programs, and more students and families with increased health knowledge and healthier behaviors. By presenting a unified voice, the efforts of the groups represented on an advisory committee "are strengthened, the burden of a complex problem is shared, broad community support is engendered, and a service that no single agency independently could provide is procured." (9)

The composition of a school health advisory committee is delineated by its purposes:

- to solicit input from professionals and lay members of the community whose knowledge and experience can contribute meaningful guidance in decisions affecting the school health program;

- to represent the diverse interests, opinions, and values operating within the community,

i.e., health, business, judiciary, religious, human services, media, parental, and student groups; and

- to provide advice and make recommendations to the school board. (10)

By establishing a common goal—meeting the needs of the community's children and their families—advisory committee members support all organizations' respective goals. This cooperative initiative coordinates existing services and, ideally, leads to true collaboration in which the design and delivery of service systems are changed to most effectively meet the needs of the whole child.

Looking At What Is Needed

The next crucial step in development of a comprehensive school health program is assessment of community needs and resources. The attitudes and standards of community members play a significant role in determining the extent of and support for school health programs. Conducting a needs assessment is a necessary step, but it does not have to be a complicated or formal undertaking. In fact, many school districts have found that written surveys result in low response levels. Talking to parents, clergy, local business people, news media representatives, and other community members at meetings or by telephone may

Checklist for Forming the School Health Advisory Committee

1. Gather information concerning the nature and function of an advisory committee.
   a. Discuss benefits and limitations with school districts that have formed school health advisory committees.
   b. Develop a list of issues common to all individuals and groups with a potential interest in school health program collaboration.
2. Define the role and responsibilities of an advisory committee.
3. Develop criteria for invitations to participants on the school health advisory committee. Committee members should include persons who are:
   - professionally and/or personally committed to school health
   - knowledgeable and experienced concerning the health and education needs of students
   - able to invest the time and energy necessary to develop and continue an effective school health program
   - leaders in the community
4. Prepare a list of persons who could represent:
   - the school board
   - the school administration
   - the school health program
   - parents
   - students
   - health care professionals (private medical/dental practitioners, public health agencies)
   - youth- and family-serving agencies
   - voluntary organizations
   - civic groups
   - the religious community
   - the judicial/legal system
   - local government agencies
   - the media
   - business and industry
5. Contact each designated representative to ask him or her to serve on the advisory committee, explaining the individual and group roles and responsibilities.
6. At the first meeting:
   - outline committee functions
   - develop goals and objectives
   - establish operating procedures (quorum requirements, how often meetings will be held, how meeting agendas will be determined, etc.)
   - elect a chairperson and recording secretary
   - establish subcommittees and assign tasks
7. Assume a long-term commitment. While individual members may change, the school health advisory committee will have a permanent function, beyond the initial planning and implementation of a school health program, in revising and maintaining the program to meet the students' and community's changing needs.

provide more information about their opinions. Reactions from community members can be an excellent source of knowledge about possible support for or opposition to proposed programs. Census data can also contribute details about socioeconomic conditions, ethnic groups, and community values.

The health concerns and health-related behaviors specific to the community deserve special attention. Many concerns are common to most school districts: drug use, drinking and driving, HIV/AIDS, the decline of physical fitness levels among children. However, behaviors and lifestyles are as diverse as the individuals who make up our communities. Before developing the school health program, it is important to know what local needs may be. Are teenage pregnancy and parenting of particular concern? Or child abuse? Or poor nutrition? What about issues specific to the environment: snakes and flash flooding dangers in the Southwest, or cold weather survival techniques in northern climates?

Determining available resources is an integral part of community assessment. In considering the community's needs and the ways to meet them, it is always a good idea to look first at the current way of doing things. This approach to assessment generally provides a descriptive, rather than an evaluative, response from those contributing their opinions and suggestions, and tends to reduce their anxiety or resistance to change. Some questions which need to be answered are:

- What health services and substance abuse programs are available to students and their families? What are the appropriate referral procedures?

- Are there local health and social services professionals who can provide information to schools, assist in program design and/or school staff training, or serve as guest speakers to parents' groups and in the classrooms?

- Is there a process for ensuring that health information available from various community agencies is consistent with what the schools are teaching?

- What about school resources—instructional or health services elements already in place or being planned, inservice training capabilities, funding for curriculum materials and staff training, personnel for planning, implementation, and continuation phases?

- What are the state education agency and state/local health department plans, requirements, and resources that concern local school health programs?

Advisory committees play an important part in ascertaining community needs and available resources. Representing the various facets of the community, committee members both reflect local concerns and have access to the information sought in the foregoing questions.

As planning proceeds, it is important to remember that open communication with the whole community requires an ongoing effort. Board members, themselves, and their advisory committee members can be effective spokespersons for school health programs. School newsletters, local newspapers, interviews on radio and television programs, and town meetings are good sources for spreading the word about the vital school health program being developed, as is the state school boards association newsletter. ■

Needs Assessment

In the *Ferguson-Florissant, Missouri, School District*, parents, students, and school staff were surveyed to determine the extent and impact of existing health education, as well as the perceived need for health education. Questions were written for elementary, middle, and high school-level respondents. For example:

- Elementary students were asked if they had discussed things like understanding feelings and community health services in their classes, and what changes they would like to see made on their school playgrounds;
- Middle and high school students were asked if and when sex education should be taught in health education classes, and what health topics they thought were important;
- Parents were surveyed to gauge opinions about sex education, whether they believed there was a need for health education, and if health education was being adequately addressed or should be expanded;
- School staff (teachers, principals, nurses, counselors, support staff) were asked how much classroom time is and should be spent on health education, and who should be responsible for teaching health.

Based on the survey, the school district formed a review committee to assess the current school health program and recommend a long-range plan. Ferguson-Florissant Health Coordinator, Joyce Espiritu, attributes much of their program's success to the extensive early involvement of parents, teachers, students, and community members.

Lincoln, Nebraska, Public Schools have commissioned a Health and Physical Education Needs Assessment to determine the priorities of their health education system. The evaluation team administrative assistant, Deanne Whenes, notes that the assessment, done through surveys, was instrumental in identifying the need for increased instruction on alcohol and drug abuse prevention. Nine separate surveys were used, targeting a variety of individuals. Separate surveys were used for doctors, dentists, drug counselors, and directors of health agencies. Unique surveys were sent to each of the following groups: elementary and secondary health and physical education teachers, elementary and secondary school principals, and parents. The surveys generally asked the respondents to choose the health education topics which they considered most important and to rank them in order of importance.

Respondents were assured that the survey results would be used to help modify the health education program to ensure that the most pressing issues were given adequate instructional time and that the concerns of the community were being addressed. Ms. Whenes says the exercise proved to be a successful way of evaluating and adapting the health program to the needs of the students as seen by the health professionals, teaching professionals, and parents of the community.

CHAPTER IV

FROM POLICIES TO PROGRAMS

What Next?

We have discussed several of the planning aspects of program development. We have talked about the need for a statement of the program's philosophy and establishment of goals. We have looked at the importance of selecting a program coordinator, involving the community members in the planning phase, organizing a broad-based advisory committee, conducting a community needs assessment, and maintaining community-wide communication.

Overlooking or delaying school health education is resulting in "health illiterate" children and adults.

These strategies are designed to ensure careful initial attention to the details that can facilitate smooth program implementation and lead to the final policy development process. Whether the school board writes new policies concerning comprehensive school health programs or revises current policies to include school health will be each board's own decision. What is of manifest importance for program implementation and continuation is that all of the elements of a comprehensive school health program be addressed through board policies. The essential nature of each program component and the cruciality of each one's relation to the others is not a new concept. This was perhaps first noted in a statement made by the Greek historian Polybius 2000 years ago: "It may have been possible in the past for things to happen in isolation, but from this time forth, the world must be seen as an organic whole where everything affects everything."

The integration of the parts of the school health program into a comprehensive whole requires that, as planning for and implementation of each element proceeds, the complete program be kept in mind. This does not mean that the entire school health program must be implemented at the same time. In fact, most school districts find that resource constraints (time, personnel, dollars) demand a step-by-step approach. A decision regarding which part or parts of the program are most needed is one which the school board must make. It is obviously better to proceed with something than to do nothing.

School Health Education

Overlooking or delaying school health education is resulting in "health illiterate" children and adults, according to Ian Newman, professor of health education at the University of Nebraska. A recent *USA Today* article reported some startling statistics from a statewide study involving eighth and 10th graders conducted by Professor Newman; statistics that are all too readily applicable across the country.

- Despite the fact that accidents are the principal cause of death among adolescents, only 40 percent of 10th grade boys in the study recalled any school instruction concerning accident prevention.

- Two-thirds of the students reported that they had not received any instruction about sexually transmitted diseases.

- While half of the 10th grade girls said they had seriously contemplated suicide, and 75 percent said they knew someone who had tried to kill themselves, only 50 percent had gotten any suicide prevention information in school.

- The students in upper grades tended to perceive alcohol, tobacco, and illegal drugs as less dangerous than did students in lower grades.

Professor Newman, along with health professionals and educators across the country, suggests that school health education can provide the information and skill development that are necessary to combat problems such as these.

Building Decision-Making Skills

Health classes today are not the same as those that most adults experienced in school, i.e., bits and pieces of information presented in physical education, biology, and/or home economics, with an emphasis on body structure and hygiene. The primary purpose of modern school health education is to provide the knowledge and decision-making skills that will enable young people to make the connection between high-risk behaviors, such as sexual activity or drug usage or poor eating habits, and the potentially harmful health consequences. Health education encourages students to take responsibility for their own futures by acting conscientiously today and establishing the health practices that will last throughout their lives.

Health instruction has the potential to influence students' health problems and, in turn, their cognitive performance and academic achievement. Health and education researchers have identified student health behaviors related to stress, poor nutrition, lack of exercise, and inadequate rest, and have documented their negative effects on accomplishment in school. Not only have these studies helped to identify and clarify student health problems, they have also clearly associated the mission of school health programs with that of learning. Educators who have questioned the inclusion of health programs in schools as being unrelated to academics and the mission of schooling can now be assured that comprehensive school health programs are essential. (11)

The Curriculum

Even when convinced that these programs are imperative, school boards must grapple with many other practical considerations. First and foremost among these is selection of a curriculum. There is a wide variety of health education curricula available, ranging from "store bought" (in the words of a Texas educator) to homemade. School districts can choose from fully-developed curricula designed to offer a comprehensive program for grades K through 12. There are also curricula that are targeted to address specific areas of concern—alcohol and drug education, sex education, HIV/AIDS education, or nutrition, for example. These

Health education encourages students to take responsibility for their own futures by acting conscientiously today and establishing the health practices that will last throughout their lives.

may be purchased as complete sets or obtained free or for minimal cost from voluntary agencies like the American Cancer Society, the American Heart Association, or the National Dairy Council. There are, in addition, examples of curricula that have been locally developed in the interest of economy or to meet local needs.

With curriculum resources available, why would a school district opt to write its own materials? Some districts have developed their curriculum for financial reasons. If budget constraints prohibit purchase of curriculum materials, or such purchase would limit or delay program implementation, the district may prefer to create its own materials and use available funds for other program elements, such as provision of inservice training. Some school districts have chosen to produce a locally-developed curriculum because they believe that the process increases school staffs' and community members' understanding of health issues and the need for comprehensive school health programs. Each district must decide independently about the advantages of purchasing a curriculum versus writing its own. Most important is to determine what best meets the established program objectives.

Advice concerning what constitutes effective, appropriate curricula is as varied as the curricula that are available. "Not all experts agree on the virtues of a . . . broad curriculum . . . . Len Tritsch, health education consultant, formerly with the Oregon Department of Education, prefers a more targeted approach that concentrates on fewer issues, but covers them in depth and demonstrates the connections among areas such as fit-

ness, nutrition, and stress management. Tritsch calls this a life management skills approach. 'I've seen too many teachers rushing through a textbook and other materials, touching many topics but not tying them together,' says Tritsch . . . . [Other experts] defend the comprehensive approach, [pointing] to research indicating that children who have repeated exposures to key topics at different stages in their education form attitudes that help them avoid bad health habits when they are older . . . . [Supporters of the more comprehensive approach say that] students exposed to comprehensive health education, including early warnings about what smoking or drugs do to the human body, are more likely to act in accordance with what they've been taught than those who have had, say, a single-focus anti-smoking or drug education program." (12)

"Student achievement can best be enhanced through the development of decision-making skills, a positive self-concept, and learning to respect others—all goals which can be achieved through a comprehensive school health program." —Mary Lou Hundt, Head of Health and Physical Education, *Arlington Heights, Illinois, High School District #214*

The challenge for local districts is to determine what, for them, represents a consistent, progressive program that encompasses all the issues deemed important. While recommendations concerning instructional approaches may vary, there are several generally recognized components of comprehensive school health education. A review of health education literature reveals a common set of ingredients that make up instructional programs.

In general, any health education curriculum and instructional program should include the following content areas:

- Accident Prevention & Safety
- Nutrition
- Community Health
- Personal Health
- Consumer Health
- Environmental Health
- Substance Use & Abuse
- Family Life Education
- Mental & Emotional Health
- Prevention & Control of Disease

The *Troy School District, Troy, Michigan*, has outlined very clearly the basic characteristics of its health education curriculum, as follows:

- instruction aimed at motivating health maintenance and promoting wellness, not just preventing disease;
- activities designed to develop decision-making skills related to health and health behaviors;
- a planned, sequential K through 12 approach based on student needs and current and emerging health concepts;
- opportunities for students to develop and demonstrate health-related knowledge, attitudes and behaviors;
- attention to the physical, mental, and emotional dimensions of health; and
- reflection of the goals and objectives of the school district.

There are numerous other instructional issues that the school board and its community advisory committee need to consider within the parameters of its own program. The list of questions on page 26 is intended to help in focusing attention on those various elements.

A Word about Training

"No aspect of their professional lives seems to disturb health teachers more than the assumption (by some educators) that any teacher—with or without a strong health background—can handle health instruction. There are more unqualified teachers teaching health than any other subject . . . ," says Patricia Pine in her report, *Promoting Health Education in Schools.* (13) Surely we would not assign mathematics or English to a

Curriculum Checklist

- ❒ Are there qualified health education instructors currently on the school staff?
- ❒ Which teachers and/or other staff members will need training?
- ❒ What kind of training will be required?
  - ❒ General health education?
  - ❒ Curriculum-specific?
  - ❒ Both?
- ❒ Who can provide the inservice training?
- ❒ When should training be provided?
  - ❒ Before curriculum selection to increase staff ability to evaluate materials?
  - ❒ After curriculum selection to facilitate use of materials chosen?
  - ❒ Both?
- ❒ What programs or activities, both in school and community wide, are currently in place that will support the instructional component of the program?
- ❒ Is the instructional program—curriculum, supporting materials, and activities—planned as student-focused and relevant to the students' experiences?
- ❒ Should health education be:
  - ❒ A separate subject?
  - ❒ Integrated into other subjects?
- ❒ How much classroom time can we allocate at each grade level for health instruction?
- ❒ What local and state technical assistance support and resources are available? Have both education and health resources been identified?
- ❒ What funds are available, locally and from state and federal sources? From private sources?
- ❒ Who can develop funding proposals if they are needed?
- ❒ What can we do now? What can we do later? What are some alternatives for providing instruction (and health services) that the school district cannot offer?
- ❒ Have we considered curriculum content and instruction for students with special needs, including English-as-a-Second-Language students and handicapped students?
- ❒ What can the school district do to assist other organizations that provide health services and education, reinforcing the need for cooperation and consistent messages from all parts of the community?

teacher with little or no preparation, nor should we do so with health education.

Surely we would not assign mathematics or English to a teacher with little or no preparation, nor should we do so with health education.

The health curriculum and staff development are inseparable pieces of the instructional component. A carefully-chosen curriculum used by teachers who are unfamiliar with the special content of health education issues and/or are unprepared for the unique presentation of health materials is, at best, a waste of time and, at worst, doomed to failure. Likewise, well-trained teachers using ineffective or inappropriate materials have little chance of succeeding in achieving their education objectives. It becomes obvious that we must consider curriculum and teacher training as equal partners in development of the instructional ingredient of a comprehensive school health program.

Training can be provided by health education consultants (a service available with most commercially-produced curricula), state school boards association trainers, state education agency trainers, regional training lab staff, or trainers from local/county/state health departments. Some universities and hospitals have training staff services available. An important factor in any inservice training program is instruction in the use of appropriate methods and materials for a specific curriculum, as well as in the basic principles of health and wellness. Several studies have indicated the direct relationship between training received by teachers and the amount of health instruction that occurs in the classroom. The School Health Education Evaluation, conducted in 1985, found that "teachers who had the complete inservice training program completed a higher percentage of the curriculum (84 percent), than those with partial or no training (76 percent and 70 percent of the program, respectively). (14)

Training

Frontier Central School District in Hamburg, New York, has undertaken "an extensive teacher training program with a district goal of training every elementary teacher." Recognizing that well-trained teachers are an essential component of any successful education program, Frontier Central has trained a core health team to implement the district's health education curriculum. Inservice training is required for all health education teachers and for all teachers who use the district-developed safety curriculum "Personal Safety K-6," as well as for those presenting HIV/AIDS education. Frontier Central's Health Department Chairperson, Donna Ketchum, believes that the emphasis on teacher training has paid off in both teacher enthusiasm about health education and the results of their efforts. She reports a noticeable decline in smoking among high school students, significant reduction in students referred for disciplinary action, and an increase in the number of students who report sexual abuse. Ms. Ketchum notes that the sex abuse issue is a painful issue to acknowledge, but necessary if the situation is to be resolved for the child. Additionally, student enrollment in the elective Human Sexuality Course continues to rise, with one-third of the senior class currently enrolled. A high participation level is also found in the health-related classes offered by the Adult Education Program. As an academic measure of Frontier Central's health education program, final exams scores for junior and senior high school students have a mean of 80 percent.

Manatee County School District, Bradenton, Florida, is not able to provide inservice training for health education teachers during classroom hours, but the district has developed an after school and weekend teacher training program which provides stipends and other training incentives. College-level courses for credit, books purchased by the school district, and luncheons with guest speakers provided by local organizations are ways in which the school district effectively communicates its belief in the importance of teacher training. Health Education and Services Supervisor, Eileen Hawblitzel, credits the strong support of the Manatee County School Board and Superintendent for the training program and the implementation of a sound health education curriculum in all the district's schools within four years.

There is another ingredient in a successful training program that deserves special mention—that of interpersonal relations skills. It is a given that good teacher-student relationships contribute positively to learning. However, because this is obvious, it is often overlooked or treated only in passing in inservice training. Aspry and Roebuck, in their book, *Kids Don't Learn from People They Don't Like*, have provided a powerful argument for the need for interpersonal relations skill training. "...[We know from our experience that] kids don't learn from people they don't like. And recognizing this truth, we will know what we have to do. [We have to provide our teachers with the training and skills that will allow them to be] models of helping, teaching and learning skills. We have what we need. The question that remains is profound in its simplicity. What will we do with what we have learned?" (15) They have demonstrated the relationship between positive teacher-student relations and increases in cognitive development and reduction in student absenteeism. (16) As a side issue, the authors note a practical ramification of increased student attendance: increased financial support for schools which are funded on a per-pupil daily attendance basis.

Inservice training for health education is not, of course, limited to the classroom teacher. In order for school health programs to be effective, administrators, school board members, school support staff, school nurses, food service personnel, and parents need to be familiar with program purposes and content. This implies a need to do much more than allot time to acquaint teachers with health education basics.

The qualities highlighted in the earlier "Wanted" advertisement describing a program coordinator are those that describe the persons whom we call educators. These are the qualities that we need to find and inspire, through training programs that provide knowledge and skills, to ensure that school health education receives the pivotal place in schools it deserves. To recall the words of Ernest Boyer, "Clearly no knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved." (17) If we are placing such a critical part of our lives in the hands of our public school teachers and staffs, we can do no less than to recognize and support their specific need for health education training.

Incentives for Inservice

The kinds of incentives that a school district may be able to provide are varied—reimbursement for training courses, time off, release time for training, additional hours of teacher aide help, relief from playground or other duties, or additional dollars for purchase of program materials. The effects of some of these "rewards" on inservice attendance have been notable. Aspry and Roebuck found that:

- Stipends resulted in 91 percent attendance rates.
- Teacher aides resulted in 89 percent attendance rates.
- Relief from duties resulted in 88 percent attendance rates.

For the control group, which received no incentives for participation in training, the attendance rate was 78 percent. (18)

Encouraging teacher participation in training may well be a key to program effectiveness. Without exception, the teachers and administrators with whom we spoke throughout the past several months have identified the need for teacher training as the most consequential factor in the practical implementation of health instruction. Several studies have suggested that teacher inservice training has a notable influence on health curriculum implementation. (19-21) Usage of curriculum in the classroom has been associated with teachers' health training skills and interpersonal abilities, as well as teachers' judgement of support for their efforts. Additionally, there is evidence that the effectiveness of the health teacher directly influences what students learn and how they will apply their knowledge. (22) On a practical level, furnishing incentives demonstrates in a material way that the school board and administration support the school health program, think training is important, and are committed to the program's success.

When effectively combined, comprehensive curriculum and staff development illustrate the efficacy of the health instruction component of school health programs. It provides the unifying focus of a health promotion program. In the words of a forgotten author, health instruction is the glue

that binds the program; it is the primary source of the one element common to all the components—health knowledge.

"Clearly no knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved."

Finding the Time

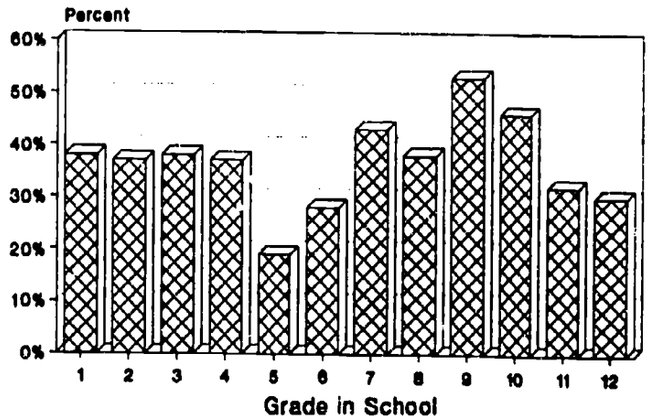
From small to large, rural to urban, poor to rich, from school districts that are thinking about school health programs to those with fully implemented programs, a common problem emerges—time. The amount of time that should be devoted to classroom health instruction is a factor that confronts all districts. An appealing aspect of comprehensive school health programs is that they offer a way to address the varied, and seemingly ever-increasing, health concerns in a systematic way.

While each district must determine the priority of health education within its schools and, thereby, the time to be afforded, health education research now offers some guidance concerning instructional time. A study sponsored by the U.S. Department of Health and Human Services shows that 1.8 hours of instruction per week (based on a six-hour school day) will produce measurable increases in student knowledge gain and improved attitudes about health, as well as stimulating some behavioral changes. (23)

Other supporting research has shown that health knowledge begins to increase after 15 hours, particularly in grades four to seven. Forty-five to 50 hours are needed to begin to affect attitudes and practices, with maximal learning and attitude/behavior changes occurring after about 60 hours of instruction in a given year. (24)

The goal currently recommended by health educators is 50 hours of classroom instruction per school year, K through 12, to achieve minimal effectiveness. When viewed from a daily perspective, that is not as overwhelming as it may sound: Fifty hours equals about 22 minutes per school day.

1st to 12th Grade Students
Receiving Physical Education



Source: National Children and Youth Fitness Study, 1984-1986

While planning for instruction time, school boards and administrators will want to keep in mind the importance of providing sequential instruction. Among school districts that have implemented school health programs, the tendency has been to teach health in grades K through six or K through eight, and offer a semester or year-long health class in high school. While the importance of beginning health education in the early school years should not be negated, neither should we neglect continuing exposure to health instruction in later years.

Good health practices seem to decline during the adolescent years. High school students get less sleep, eat less balanced diets and more junk food, and get less exercise than they did when they were younger. And, yet, the reinforcement of health-enhancing behaviors by schools (through health education) is discontinued or lessens at the very time when the students themselves are the most likely to discontinue them. If we want our children to build and maintain healthy practices, we will have to make the investment of time throughout their school years.

Health Promotion and PE Class

Regular physical exercise is an important ingredient in a healthy lifestyle. Given that the health habits established in childhood carry over into adulthood, physical education classes can be seen as critical in a preventive health education program. As noted in the *Journal of School Health* (December 1987, Vol. 57, No. 10), school-based physical education programs represent an

existing resource for health education because of their health-oriented natures. In addition, there is evidence that physical education enhances academic performance. (25)

Comprehensive school health programs are placing greater emphasis on PE programs that promote lifelong physical activity and fitness, i.e., those programs that stress increased physical activity, higher-order cognitive and affective objectives, and health-related fitness testing rather than the more traditional sports skills-oriented programs.

The Healthy People 2000 Objectives (U.S. Department of Health and Human Services, Public Health Service) include several objectives related to physical fitness and exercise. Among them are two that apply directly to school health programs:

In the words of a forgotten author, health instruction is the glue that binds the program; it is the primary source of the one element common to all the components—health knowledge.

- By the year 2000, to increase to 50 percent the number of schools offering daily physical education programs for grades 1 through 12. Baseline: 36 percent (Objective 1.8)

- By the year 2000, to increase to 50 percent the proportion of school physical education classes spent in actual physical activity and stressing lifetime physical activities. Baseline: 27 percent (Objective 1.9) (26)

The National Children and Youth Fitness Studies, conducted in 1984 and 1986 by the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD), provide some startling statistics. While 97 percent of all elementary school students participate in a physical education program, the numbers decrease in succeeding grades to 36 percent of all students in daily PE classes in grades seven through 12. Even worse are estimates concerning class time spent in moderate to vigorous physical activity—often as low as three minutes per 30 minute period. (27)

The health-enhancing potential of physical education programs warrants attention during the planning and implementation of school health instructional programs. PE programs that emphasize health-related physical fitness over athletic ability should be promoted. Programs that include regard for cardiorespiratory endurance, body fat levels, flexibility, and muscular strength and endurance are a necessary component of an effective school health program. It is all a part of what we mean when we refer to comprehensive school health programs.

School Health Services

Reading the current literature about school health services and talking with school health personnel discloses a consistent theme: School health services are not well understood and, consequently, not effectively used in school health programs. School nurses and other school health care staff members invariably note that they represent a largely untapped resource for providing a variety of services beyond basic health care—as advocates for school health programs, health teachers, health counselors, and links to community assets.

School health services are an essential link in the health education-health care chain. Recognizing that the schools' primary function is to teach, and that school health services are not intended to take the place of the communities' health care resources, educators must still deal with the unhealthy student whose attention is focused on his or her problems, not on learning. It is for this reason that the health of our school children assumes a primacy which demands our regard.

Establishing goals for school health services is a necessary part of a comprehensive school health program. In addition to prescribing the school health services available, goals provide the basis for coordinating the school district's health services and health instruction, and offer the rationale for expanding or improving the schools' health programs. The extent of the school health services offered reflects the community's standards and indicates the interest and commitment of the school board to the crucial relationship between

good health and a good education.

The NSBA Consortium to Foster Comprehensive School Health Programs in the Public Schools has developed a list of basic school health services which may aid schools in developing a framework for services. These include:

- Health assessments, which should incorporate:
  - — immunizations
  - — vision screening
  - — hearing screening
  - — dental screening
  - — blood pressure screening
  - — blood cholesterol testing
  - — body fat level assessment
  - — scoliosis screening
  - — developmental needs appraisal
  - — special health needs appraisal
- Counseling and referrals
- Health records maintenance

Schools might also consider adding separate physical examinations for athletes and establishing faculty and staff health promotion programs.

A first reaction to such a list of health services may be to say, "We can't do all that. We have too many students/too few health staff members." Do not despair. Community health resources can help, but it is imperative to establish cooperative agreements with local health service providers (health departments, health clinics, and independent medical practitioners) to assist the school district in meeting students' basic health needs. This need highlights the importance of involving the local medical community in overall program planning and development.

What Health Services Do We Need?

The health needs of each school district's students will, of course, vary from community to community. The local needs assessment will be very helpful in identifying many of those needs that are specific to each community. In general, it is safe to assume that adolescent students will neglect their health. In fact, teenagers have the lowest rate of visits to doctors of any age group, and many school-age children do not receive regular medical attention. Studies conducted in the 1980s showed that as many as 33 percent of children aged six to 16 had not seen a doctor in the previous 12 months, and 15 percent had no regular medical care source. These are average figures, so numbers are even higher in areas with high poverty levels where preventive health care is often neglected in economically hard times.(28)

The purpose of providing school health services is to support the educational process.

The purpose of providing school health services is to support the educational process. In essence, health services are needed to enable each child to be healthy enough to learn. We may not relish the undertaking of another task in our schools but, in order to fulfill the responsibility of offering educational opportunity to all Americans, we need to recognize and deal with their health needs, as they impact on our schools.

The Role of the School Nurse

When we think of school health services, we think first of the school nurse. Indeed, it is usually the school nurse who takes care of the students' daily health needs in school, identifies health problems, maintains student health records, and recommends other sources of care for serious or long-term problems. In schools without a full-time nurse, classroom teachers and school staff are well aware of the need for regular school health staff, often commenting that they may spend as much as half of their school day dealing with students' health needs.

A consortium of six national nursing associations, which includes the National Association of School Nurses, recommends a school nurse:student ratio of 1:750. In schools with a significant number of special needs students, the ratio should be much lower, 1:225. While school district resources may limit the ability to provide optimal numbers of health service staff, there are less ideal, but workable alternatives: a part-time school nurse, whose time is shared by two or more schools; school nurse practitioners, who are licensed by the state to diagnose minor illness and dispense some medications; and/or health aides, who work un-

der the supervision of a part-time nurse and who can dispense medications (with doctor/parental approval), conduct health screenings, and arrange referrals to other health care providers.

The school nurse, or whoever serves in his or her stead, should play an integral role in the overall school health program. There are numerous ways in which the school's primary health care giver can augment development and implementation of a comprehensive program. He or she can and should:

- take part in curriculum selection or development;
- participate in inservice training;
- provide information regarding health issues;
- identify health-related problems that affect school performance and/or attendance (symptoms of depression, lack of energy, drug abuse, child abuse);
- promote staff wellness and physical fitness;
- provide classroom instruction;
- serve as a link to community health resources; and
- facilitate integration of program components, using student visits to nurse's office as teaching opportunities.

As the central actor in the health services component of a comprehensive school health program, the school nurse is both the primary health care provider and a valuable source of information and support.

The school nurse is both the primary health care provider and a valuable source of information and support.

School-Based and School-Adjacent Health Clinics

Several school district., particularly those with large numbers of at-risk students, have opted to establish school-based or school-adjacent health clinics to provide for the health needs of their children. (School-adjacent refers to those clinics that are on or near school campuses, but not located in the school building, and are operated by public health agencies.) These clinics make health care services available to students who might otherwise be unserved for a variety of reasons, financial ability being just one. Many families who cannot afford medical care do not have insurance coverage, yet are not eligible for Medicare or Medicaid; their health needs often remain unattended. Working parents frequently find it difficult to take children to the doctor or stay home with them when they are sick. Additionally, adolescents are especially unreliable about making and keeping appointments, and usually do not follow directions very well. School-based clinics provide teachers and school nurses with the opportunity to intervene in health-threatening situations, or to prevent health problems by early detection. In Chapter VI, we will look at youth-serving clinics in two school districts where school board members and school staff believe that attendance and student achievement have improved as a result of the health services provided: Holyoke, Massachusetts and Dallas, Texas.

While noting the advantages to be gained from clinics, we should not ignore a major objection. Many parents and community members equate school-based or school-adjacent clinics with family planning services, i.e., counseling about and/or distribution of contraceptive inform..tion or devices, such as condoms or birth control prescriptions. Although only 20 percent of all student visits to scho. ased clinics are concerned with family planning issues (29), it is a matter that needs to be addressed directly through the school board's goals for district health services.

Medical Services Provided at School-Based Clinics

Percentage of All School-Based Clinics Offering Services

Medical Service	% of Clinics Providing Service
Assessment/Referral to Community Health Care	90
Assessment/Referral to Private Physician	85
Chronic Illness Management	87
Dental Services	31
Diagnosis/Treatment of Minor Injuries	98
Diagnosis/Treatment of STDs	90
Dispense Medication	74
Special Needs Screenings	48
General Physicals	96
Primary Health Care	97
Immunizations	87
Laboratory Tests	97

Source: Center for Population Options, 1990

Health Services

In keeping with the *Pottstown, Pennsylvania, School District's* emphasis on prevention of disease and promotion of healthy attitudes and behaviors, the district has developed objectives which specifically undergird the health services component of their school health program. These include for all students:

- development of sound nutritional habits
- effective use of community health resources
- knowledge of disease prevention
- development of good hygiene and mental health practices
- knowledge of safety and first aid
- avoidance of substance abuse
- attainment of physical fitness
- development of healthy dental practices

These objectives evolved from careful consideration of student needs and how to meet those needs in ways that are relevant to the experiences and attitudes of the children.

Program coordinator, Liane Heydt, notes that the activity-based health education component of Pottstown's program has been designed to reinforce the objectives and provide the maximum amount of classroom instruction within a tightly-structured schedule. Using a "high impact" approach, the program combines several innovative concepts that include use of specially-selected videos to provide information in ways that are particularly appealing to various age and ability levels; development of games and activities that permit "hands-on" application of the information presented, as well as subtly reinforcing the program's health objectives; and involvement of parents in their children's health education through participation in assigned "home activities."

Given time constraints which limit the number of hours available for health education in the classroom, the strong interaction between the health services and health instruction components of Pottstown's creative school health program provides the all-important reinforcement between health knowledge and healthy behavior necessary for an effective program.

A holistic view of student health and strong community support are key factors in the *Beverly, Massachusetts, School District's* school health program. Health services are extensive and are reinforced in classroom instruction, involving school nurses and counselors, as well as medical care providers from the community. Health services provided to all students include:

- inoculation checks
- vision and hearing screening
- dental screening, including sealants and repair of cavities
- fluoride rinse program
- physical evaluations
- speech therapy
- postural screening
- pediculosis screening
- health assessments for individual education plans (IEP)
- child abuse assessments
- Kindergarten and pre-Kindergarten screening
- management of asthmatics
- counseling and referral

Tying together health services and health instruction, Beverly Hospital's Emergency Room RNs talk to first graders about emergency medical care; medical personnel from North Shore Children's Hospital speak to Kindergartners in an attempt to reduce the natural anxiety about going to the hospital; local dentists make classroom presentations to third graders; and nurses talk with fourth graders about drugs. Beverly's Director of Health Education, Dr. Thomas Durkin, believes that bringing local health professionals into the school has helped strengthen the school health program and the bond between school and community.

The health services component of the district's school health program has been further buttressed by the School-Home Health Outreach Program, which provides parent support groups focusing on stressful adolescent issues and serves as an after-school-hours link for students with health problems. Additionally, school health services providers are involved in providing sexuality education for mentally and physically handicapped students, and inservice training on health issues, offered to school nurses, counselors, teachers, and special services personnel.

Dr. Durkin stresses that the coalition building which has occurred between the school district and community has been both a main focus of Beverley's school health program and a primary reason for the program's success.

Community support is key to the success of a school-based or school-adjacent clinic, and parental and community involvement in the planning phase is perhaps the most important element. When involvement is strong, opposition tends to be limited.

The School Counselor

Just as youth health clinic services encompass more than family planning, so does a holistic approach to health involve more than attention to physical well-being. The whole child has physical, emotional, intellectual, and social dimensions with corresponding needs. In order to serve the whole child, we have to ensure collaboration among the various professionals who operate within the school setting and the community.

The school counselor is the person most likely to work with students and other school personnel in the areas of emotional, mental, and social growth and development. Counselors need to consult with school nurses and other medical staff about students' physical problems, with psychologists and social workers in regard to testing and home or social adjustment problems, and with representatives of the judicial system when necessary. With their unique training and clinical skills, counselors are the central figures in assessing the overall needs of students and in coordinating the services to meet those needs.

The Health Connection

Nowhere is collaboration more important in a school health program than in the provision of health services. Certainly no man is an island, nor can any entity within our communities offer every service or meet every need. We do not expect our medical practitioners to be totally responsible for health education, and we cannot expect our school health programs to offer services for every health need. The healthy student is, in fact, attended by a profusion of service providers.

Coordination of these services falls naturally to the school counselor and the school nurse. Dealing with student needs encompassing everything from eyeglasses and dental care to drug rehabilitation and domestic violence, counselors and nurses need to be able to call upon a broad network of professional and voluntary agencies and individuals, including public and private health organizations, professional societies, private practitioners, and service clubs.

Ideally, representatives of these groups will be members of the school district's health advisory committee, involved in establishing and maintaining student health. As health providers, they are usually eager to contribute to school efforts in promoting good health practices, fostering prevention, and establishing the mechanisms for early intervention and treatment. Linkages between the school and the community's health resources may be informal or highly structured; whatever the form, development of the referral system between school and community providers is critical to the success of the school health program and the goals of ensuring healthy students.

Whatever form school health services take, their value to the education process seems undeniable. However, despite that value, school health services still tend to be among the first areas to sustain cuts when school budgets decrease. The quantity and quality of school health services that can be provided by the school district will have to be weighed by each school board in terms of its benefit to the community now and in the future.

There are innumerable ways in which subtle messages about health and wellness are communicated.

Healthy School Environment

The final component of a comprehensive school health program is the school environment. Beyond the obvious bricks and mortar issues of building codes, proper lighting and ventilation, and clean air and water, a healthy school environment denotes a safe and healthy physical and emotional setting, nutritional food services, and healthy and supportive school personnel.

The importance of the school environment becomes clear when we consider that our children, between the ages of five and 18, spend the major-

ity of their waking hours in school. While school officials have long been aware of the need to provide a healthy environment in the physical sense, the significance of promoting a suitable emotional-mental-social setting has been recognized more recently. There are innumerable ways in which subtle messages about health and wellness are communicated: clean school buildings and grounds, safety regulations and drills, nutritional meals, and smoking policies are examples of the way in which we say without words that healthy living is important. Additionally, role modeling and the quality of interpersonal relationships between administrators, teachers, and students can enhance or negate what we are trying to teach in health education.

The physical details of school management are most likely to capture our attention and our time—a faulty heating system or leaking pipe in the boys' bathroom demands immediate care. The emotional factors are not only more difficult to identify, but require a great deal more time and insight to "fix."

We have discussed the importance of interpersonal relationships in health instruction, stressing the need for good rapport between teacher and learner. The quality of relationships is of equal importance in creating and maintaining a healthy environment. To paraphrase our earlier theme (Kids don't learn from people they don't like.), people don't work well with people they don't like. Not all faculty and staff members will be, or need to be, best of friends. However, developing and sustaining an atmosphere of mutual respect for each other is a determining factor in reducing daily stress levels and in providing models for positive interaction to students.

"Wellness for employees—that's where you start. A healthy staff will be happier and more productive and, most importantly, will provide an example for the student."—Eileen Hawblitzel, Supervisor, School Health Program, Manatee County School District, Bradenton, Florida

Employee Wellness Programs

School boards and administrators are always struggling with budget concerns, i.e., ways to make the available dollars meet the ever-expanding needs of the school district. The rising cost of health care is one of the increasing costs that must be confronted. Costs incurred by staff illness include medical insurance expenditures, loss of productivity, and payments for substitutes. School

Wellness

In the *Beaver, Pennsylvania, Area School District*, health education has been identified as the number one priority according to Assistant Superintendent, Betty Sue Schaughency. That priority is reflected in the district's wellness program with its heavy parental involvement. The policy states that the underlying premise or critical attribute of Beaver Area's health program is the belief that adult role models must value keeping their own bodies healthy and must be committed to wellness lifestyles if we are serious about these goals for students. Therefore, the target population is not limited to the students and their school health curriculum; the target population includes staff and parents.

Objectives of the program include development of a staff wellness component and a community wellness component.

To this end, the district and the Medical Center of Beaver County education staff have conducted evening sessions for parents, providing the same content that the children received in school. Other workshops for the parents have focused on family self-appraisals in relation to health and safety practices with an emphasis on developing plans for "family wellness." The program focus has grown fro school staff and parents as the target audience to include the whole community.

Ms. Schaughency stresses employee and parent wellness as a critical element of the district's school health programs saying, "What you focus on, expands." Beaver's emphasis on school staff and parental well-being has resulted in healthy adults and good health role models for students.

employee wellness programs may provide a partial solution.

When we consider that the success of our school programs depends upon the capabilities of our teachers and other school personnel, keeping them healthy seems a worthy goal. Employee wellness programs offer a number of approaches to increase job satisfaction, morale, and health among school faculty and staff, and do not have to be expensive undertakings. Local health departments and hospitals are often willing to offer their services in providing a variety of health and fitness classes: aerobics, stress management, weight control, and smoking cessation are a few examples. School staff members or parents may be able to conduct exercise classes or organize special activities, such as a biking or jogging club or weekend hikes. Using school facilities for exercise classes reduces any associated costs.

Someone to organize a program—perhaps the school health program coordinator or school nurse—and promotion of the program by school leadership are the two necessary ingredients.

Everyone will feel better, look better, and the students will benefit from reinforcement of their classroom instruction by example.

The case for healthy school environments is elucidated in the following statement:

"If we are serious about improving the quality of education, we must commit ourselves to improving the 'quality of life' that is experienced moment to moment by those who inhabit or are affected by schools. Only when we can truly say our schools are physically and psychologically safe, can we say our nation is no longer at risk." (30)

The Cost of School Health: The Budget

In this section, we will look at what is included in the school health program budget and some sources of outside funding. In order to determine program costs, it is necessary to consider what is currently being spent for health education and health services. Frequently, school health program components are reflected in different parts of the general education budget for the school district. School health program coordinators report per-pupil costs that vary from 20 cents to more than $100. This is not because the actual costs are so different from program to program, but because some program budgets show only expenditures for materials, while others reflect such high-cost items as classroom teacher time, substitute teacher costs for inservice training, and dollars for health services.

Expenditures for health programs may appear in various places in school budgets—textbooks and other teaching materials, salaries, health services and supplies, employee support programs—so it is advisable to review the entire general education budget in determining current costs. It is also important to ask what program elements must be added to the school health program budget, in total or in part, to develop the program that will meet the community's current and anticipated needs. The answer to this question will have a major impact on the school board's long-range planning and on the development of timelines for the program's implementation.

The following list of potential program cost areas may help in assessing current budget resources and future needs.

- *Program Development Time:*
  substitute teacher costs for staff involved in planning during the school day

- *Materials:*
  purchase of textbooks or curriculum development time, and other materials, including supporting print materials, audio-visuals, and teaching guides.

- *Staff:*
  program coordinator
  health teachers (high school)
  inservice training, including substitute teacher costs for inservice conducted during the school day

- *Health Services:*
  school staff
  contract services
  school facilities, equipment, supplies

- *Food Services:*
  Are there or will there be any additional costs due to improvements in providing more nutritional meals and snacks?

- *Staff Wellness Program*
- *School Environment Improvements:* including the building, grounds, safety considerations

Estimating Costs

There is some help available to school boards in determining school health program costs. The NSBA Comprehensive School Health Programs Database provides information from over 100 school districts which have implemented school health programs. The database identifies school districts similar to yours and can provide you with the names and telephone numbers of program coordinators in those districts who can tell you what they have done and how they did it, and about the associated costs.

An indicator of the costs associated with the instructional component of a school health program has been provided by a 1985 study conducted by Abt Associates, Inc. of Cambridge, Massachusetts. The study, called the School Health Education Evaluation (SHEE), was designed to assess the status and effectiveness of school health education. SHEE considered the results of four instruction programs, involving over 30,000 students, grades four through seven, from 1,071 classrooms in 20 states. Total costs (materials, teacher training, and implementation in the classroom) of the participating programs averaged about $53 per student, with individual program costs ranging from $23 to $84 per student. Both start-up costs and implementation costs were considered by SHEE. Start-up expenses include materials purchased/developed and teacher training; implementation costs consist of classroom instruction time, i.e., teacher salaries and fixed operating expenses, resources not usually assigned by curriculum topic. (31)

What Other Funding is Available?

Innovative program coordinators have identified several sources of outside funding for comprehensive school health programs. These sources include:

- federal and state grants from departments of education, public health, mental health, human services, highway safety, and substance abuse agencies;
- private industry, e.g., insurance companies;
- professional and voluntary organizations, e.g., American Medical Association, American Heart Association, American Cancer Society, American Lung Association, National Dairy Council;
- fraternal and social organizations, e.g., Lions Clubs, Kiwanis Clubs, Rotary Clubs;
- foundations;
- colleges and universities;
- hospitals and health service groups; and
- community agencies for health, fire, recreation, and social services.

In addition to dollars, these sources frequently can provide supplementary materials, administrative support for program management, teacher and peer counseling training, and health services personnel.

It is important to include funding and support sources in a working partnership with the school health program. Resource persons and organizations need to have a sense of ownership in the program, to share in its development, and to be aware of all the program's successes. As partners, they contribute their expertise, exercise their leadership skills, use their fundraising and political abilities, and truly advance the formation of a program that works in the community. Involvement in a program that reaps tangible results and that provides good news, as comprehensive school health programs do, will ensure the continuing interest and commitment of the community. That support, in turn, will determine the long-term success of the school health program.

The Resource section of this guide provides additional information concerning potential sources of funding for comprehensive school health programs.

Regional Programs: An Innovative Approach to Cost Cutting

In times of tightening budgets, some school districts are sharing education resources. These regional and interdistrict cooperative efforts provide reduced costs in terms of dollars and personnel, and allow program continuity.

The *New York BOCES* (Bureau of Cooperative Educational Services) serves multiple school districts. In the *Erie-Chautauqua-Cattaraugus BOCES*, in western New York State, some 28 districts benefit from this collaborative approach. Regional health coordinator, Lynn Delevan, points out the advantages which accrue to school districts participating in BOCES' programs:

- Sequential, comprehensive health education is offered to every student.
- All schools have a complete set of instructional materials.
- All teachers are trained.
- School staff does not have to search for resources to implement or sustain their school health programs. Applications for federal and state monies and for grants are written on behalf of the districts by BOCES.
- School nurses and other health service staff receive inservice training, along with health teachers.
- Substance abuse counselors are provided to the districts by BOCES.
- Combined resources supply school districts with many other services that they might not be able to provide individually:
  - HIV education for K through 12 classes and the community;
  - alternative education programs for pregnant/parenting teens;
  - identification of special needs within each district and development of programs to meet those needs, such as health services for migrant children and Indian children; and
  - employee wellness programs.

Costs to the participating school districts are about $7 per student, though most districts actually receive BOCES' services free because of offsetting of expenses from grant revenues.

The Broome-Tioga BOCES, in central New York State, incorporates 18 school districts, providing similar support to its largely rural schools. School health programs coordinator, Gae Riddleberger, reports that they are part of a pilot program to expand BOCES' role in comprehensive school health programs. During the 1990-91 school year, the health education needs of special education students received particular attention.

The Gratiot-Isabella Intermediate School District in Mt. Pleasant, Michigan, has combined resources to provide health education materials, training, technical assistance, and administrative support for school health programs throughout a five-county region. Training includes 30 hours of inservice specific to grade levels with retraining when teachers change grades. Administrators and school board members are encouraged to attend the training sessions. Funding for the Gratiot-Isabella Intermediate School District programs is 80 percent ISD dollars, which come from federal programs and grants, and 20 percent school district dollars. Gratiot-Isabella is one of 26 regional sites in Michigan which coordinate support for school health programs using the Michigan Model for Comprehensive School Health Education.

These interdistrict programs offer an efficient means of sharing available resources and promoting coordination in program planning. They have the added advantage of being able to focus attention on particular issues without neglecting the comprehensive nature of school health. The Erie-C-C BOCES provides a good example of this function in its reduction of teen pregnancy in western New York State by 38 percent.

A disadvantage of the interdistrict approach to school health programs is the absence of a program coordinator within the school district. Monitoring the effectiveness of program components, particularly in regard to implementation of the curriculum in the classroom, makes program evaluation difficult. However, shared-program proponents say that this deficiency is outweighed by the advantages gained from combining resources and efforts to provide quality school health programs.

Assessing the Program

Program evaluation plans should be part of the program design. School boards will want to determine how the evaluations should be conducted and what outcomes will demonstrate that the program is effective, i.e., meeting the stated program goals. Evaluations are necessary to justify program costs and to indicate how the program might be improved.

School board members and administrators will be interested in evaluation of the program process: Is the program well-administered? Are staff members appropriately prepared for program responsibilities? Are materials and teaching methods suitable? They will also be interested in program outcomes. While outcomes are an essential part of program evaluation, they are difficult. Since school health programs are intended to affect attitudes and behaviors, as well as impart knowledge, and because attitudes and behaviors are less susceptible to objective measurement, at least part of the program outcomes assessment must be based on subjective judgements.

Annual beginning and ending tests can be administered to students to determine specific knowledge gain and to track self-reported changes in attitudes and behaviors. School health records, as well as data from community health care providers and other community agencies, can provide information concerning changes in student absenteeism, instances of health and behavioral problems, and participation in healthy activities. Changes in staff health attitudes and behaviors can be assessed in the same way to determine the impact of employee wellness programs.

Of perhaps equal importance in determining the effectiveness of a comprehensive school health program is the more informal feedback concerning the program from students, teachers, parents, and community members. Do those involved in the program perceive that it is of value, that it is working? After all, the most important reason for implementing a school health program is not to increase productivity or reduce medical costs, but to provide our children with the means for leading happier, healthier, and more constructive lives.

Information regarding program efficacy is indispensable in the decision-making process that drives the development and implementation of comprehensive school health programs. The purpose of any evaluation should be to determine if identified needs are being met, and to revise program elements, as appropriate, to better meet current and anticipated needs.

The physical, emotional, and academic health of our children—both at present and in the fu-

What Will It Cost?

Concern about unknown or unanticipated costs is an all-too-frequent stumbling block in the way of implementing school health programs. School board members and administrators cite the difficulty of estimating overall costs of health programs, setting up a system to ensure continuous funding at a prescribed level, and securing funding for special projects. The *Pewaukee, Wisconsin, Public Schools* have dealt with this barrier by incorporating a formula for funding into the general education budget, which ensures a constant level of support for the school health program. An estimated health education budget of $4,000 for the school year 1989-90 served a student population of 1,450 and covered the costs of materials such as computer hardware used in the classroom, subscription costs for a health magazine used by the students, and special activities. Program funding is based on a percentage of overall per-student education costs; dollars are allocated to the health education program based on the amount of time a student spends in school-day instruction in health and physical education activities. As part of the district's planning, Pewaukee's teachers were asked to rate subjects taught on a role/function basis. Health education received the primary level of importance, making it comparable to mathematics, science, English, and reading in its effect on children's lives, and determining its solid place in the education budget. John Hisgen, School Health Coordinator, believes this type of systematic funding of health education is imperative in achieving a comprehensive school health program. While federal and state grants contribute to Pewaukee's funding, they are considered secondary in importance.

ture—is our collective responsibility. In meeting that responsibility, we have a powerful tool at hand in the form of comprehensive school health programs. "When it is effective, comprehensive school health education maximizes the prospect that students will be able to make health-enhancing decisions which allow them to live artfully, to grow and develop naturally, and ultimately, to become fulfilled human beings. To foster this ultimate end is the *raison d'etre* of the place we call school." (32) ■

Evaluations

Unlike other school subjects, effective health education must reflect itself not only in subject knowledge, but in modification of risk-taking behaviors, attitudinal shifts toward health, emotional well-being due to enhanced self-esteem, and changes in behavior. How we measure the nonobjective standards can be quite a challenge. Health educators, school health professionals, and curriculum and program coordinators have expressed a belief that their health programs are having the desired effects in many of the areas mentioned above, but can cite only anecdotal information to support their beliefs.

In an attempt to demonstrate objective outcomes of their school health program, the *Denver, Colorado, Public Schools* participated in an evaluation study by the University of Colorado at Boulder's Institute of Behavioral Sciences. This ongoing study is aimed at determining developmental issues which may affect young peoples' health and is being conducted over a five-year period. Funded by the W.T. Grant Foundation, the evaluation looks at such factors as personality, perceived social environment, behavior, and assessment as important elements of a young person's development, affecting their attitudes toward health.

Dr. Richard Jessor and his colleagues at the University developed a comprehensive 40-page health behavior questionnaire which they administered initially to seventh, eighth, and ninth grade students and, subsequently, to the same students for three consecutive years. The results of the surveys are reported to the school district to help with curriculum planning and to indicate general trends and differences between schools. While names of students and participating schools are confidential, the reports do include appropriate demographic information so that school districts can relate results to their needs.

The three-year surveying process was begun in 1989, so information concerning specific long-term results is not yet available. Middle School students were targeted because of the complex nature of the survey and certain minimum levels of reading and comprehension skills needed to fully comprehend the questions. Though this study was quite expensive, approximately $100,000 per year, it is hoped that the resulting survey tool and analytic process will be transferrable to other school districts at considerably less cost.

The Grafton, North Dakota, School District utilizes its school record-keeping procedures to provide a baseline and to indicate changes in its school population's health behaviors and attitudes. Through tracking the number of students seeking or referred to health services (the school nurses' offices or school counselors) and through absentee records, several changes were noted that could be attributed to the district's school health program:

- greater awareness and understanding of health problems on the part of students, teachers, and parents, with resulting increases in referrals or help sought and decreases in discipline problems;
- decreases in teenage pregnancy rates;
- increases in counseling sought or students referred for pregnancy/parenting, drug and alcohol abuse, dysfunctional families, excessive absenteeism, poor attitude/low self-esteem, lack of motivation, weight problems, and personal hygiene; and
- greater coordination of health and other subjects with resulting reinforcement of two or more areas of learning.

Other behavior changes included increases in smoking, indicating the need to stress tobacco education and consider tobacco-free school policies.

All these results, shared with parents and the community, have had the effect of increasing enthusiasm about and confidence in Grafton's school health program. Nothing breeds success like success, and the Grafton school district effectively demonstrates its program's accomplishments in a low-cost way, by using existing record-keeping procedures.

CHAPTER V

IT BEARS REPEATING

Underlying the forgoing consideration of the need for comprehensive school health programs, the descriptions of existing exemplary programs and their components in school districts across the country, and the practical suggestions for planning and implementing school health programs are four basic assumptions:

- that social changes have produced major health problems among our children that have directly impacted on schools and their ability to educate;
- that academic achievement and student self-esteem and well-being are inextricably intertwined;
- that responsibility for the physical, emotional, social, and intellectual health of children is that of the whole community and of all its institutions; and
- that the school is often best positioned to serve as the community's center for meeting the needs of the whole child.

Responding to these challenges, school leaders are finding that comprehensive school health programs are giving them the means for addressing the issues and achieving many of the results they are seeking. Among the most frequent changes that school districts are attributing to their school health programs are:

- improvements in attendance rates;
- reductions in substitute teacher costs;
- decreases in tobacco use among students and staff;
- lower teenage pregnancy rates;
- increased participation in physical fitness activities;
- greater interest in weight control, cholesterol levels, and healthier eating habits; and
- better understanding of the relationships among health/learning/behavior, with resulting increases in teacher referrals/student self-referrals to school health and counseling services and decreases in disciplinary problems.

Good planning is fundamental to the development of effective programs and achievement of desired results. In summarizing the planning process and implementation of school health programs, there are some indispensable steps that bear repeating.

1. ***Determine the priority of health and well-being within the community.*** In order to garner the resources that are necessary to develop and maintain school health programs, the physical and emotional health of students must be linked directly to learning and be perceived as beneficial in providing them with the opportunity for successful lives. The priority afforded school health will drive the development of the program's philosophy and goals.

2. ***Commit the school board and the school administration to supporting the school health program.*** The backing of school leaders is key to assuring the actual implementation of health education and school health services, as well as ensuring the continuity of any program. School board policies that clearly state this commitment are essential. Sound policies provide clear guidance for the administration of school health programs (including attention to the many issues ranging from the familiar—dispensing medication to students, establishing school facility health and safety requirements, providing appropriate inservice training for teachers—to the new—anticipating HIV-infected students and/or staff, meeting nutritional needs of students, promoting employee wellness programs) and assure that program objectives and goals augment the district's overall education goals.

3. ***Assess the needs and wants of the community.*** Along with the benefits we gain from the diversity of our unique American society come a variety of attitudes, values, and desires. Each school board will have to determine what its community

wants and needs in its school health program, and what the school community can do. The success of each program will be affected by its relevance to issues of importance in the community and its sensitivity to the opinions and cultural/linguistic backgrounds of its citizens.

4. ***Enlist community support and establish a School Health Advisory Committee.*** Community advice and involvement are integral to the school district's ability to respond to the demands placed on it to serve the whole child. The sharing of ideas and coordination of resources increase the potential for developing effective school health programs and, simultaneously, enhance the visibility and viability of those groups represented on the advisory committee—thereby making them more effective. The responsibility of this committee is, as its name suggests, to provide advice from its members and feedback from the community to the school board. Additionally, it serves as the network from which school-community partnerships can be formed. The school health advisory committee should be representative of parents, teachers, school health service personnel, community health agencies and private practitioners, social service institutions (including welfare, police, fire, and justice systems), school administrators, students, business and industry, and civic and religious organizations.

5. ***Assign a school health program coordinator.*** Coordinating and integrating all the elements of a school health program should be the function of a central person with good organizational and leadership skills. School boards and administrators need to be sure that the coordinator has sufficient time and knowledge to carry out all the tasks required to develop and implement an effective, comprehensive program. These responsibilities include:

- supervising all aspects of the school health program, including special activities;
- coordinating development/selection of the health education curriculum with input from the advisory committee;
- providing for inservice training;
- coordinating the school health program with community agencies' services and activities;
- organizing meetings to share program information with parents and to seek their involvement;
- facilitating health guidance and counseling;
- administering the staff wellness program;
- writing grant proposals for supporting funding;
- developing and maintaining an ongoing evaluation plan; and
- assisting with classroom instruction.

6. ***Choose the right curriculum.*** Whether to purchase or develop health education materials, whether to present health education as a separate subject or integrate it into other subjects, and whether to implement a K through 12 curriculum incrementally or simultaneously are decisions that will have to be made by each school district after considering the local commitment to school health and the available resources. There are many good curricula in existence—some commercially produced, some developed by other school districts, and others that are available from government and private organizations. Whatever curriculum the school district chooses, it should be comprehensive, sequentially developed, and age- and culturally-appropriate. Topics covered should include:

- Accident prevention and safety
- Nutrition
- Community health
- Personal health, including physical fitness
- Consumer health
- Environmental health
- Substance use/abuse
- Family life education
- Mental and emotional health
- Prevention and control of disease, including sexually transmitted diseases and HIV infection

7. ***Train teachers and school staff members.*** Enabling classroom teachers to feel comfortable with and enthusiastic about the new health education curriculum is necessary for its successful implementation. Beyond the classroom, school staff members should be involved in inservice training that gives them the knowledge and skills to reinforce the health lessons taught. School nurses, counselors,

food service personnel, administrators, and office and custodial staff all play important roles in establishing the healthy school environment that promotes good, healthy attitudes and behaviors; they should be included in training.

8. ***Link instruction and health services.*** School health services are an essential link in the health education-health care chain. School health services are not designed to take the place of the community's health care resources, but rather to be linked to them in providing care for the whole child. Basic school health services include:

- Health assessments, including immunizations
- Vision and hearing screenings
- Dental screenings
- Blood pressure checks
- Blood cholesterol testing
- Body fat level assessments
- Scoliosis screenings
- Developmental needs appraisals
- Special health needs appraisals
- Counseling and referrals
- Health records maintenance

Schools might also include physical examinations for athletes and a health promotion program for faculty and staff.

9. ***Concentrate on a healthy school environment.*** The school as a healthy and safe place for students and staff means more than a well-maintained building. That is important, of course, not only for physical health and safety but for the subliminal message sent by a clean and well-kept facility: We care about you and your surroundings. Beyond the building site, a healthy school is one that is emotionally and psychologically healthy, a place in which everyone can be accepted as a good person, where positive behaviors are rewarded and negative behaviors are fairly punished, where people like each other and like what they are doing. An emotionally and physically healthy school staff which feels good about itself will be reflected in students who also feel good and in improved performance on everyone's part.

That concept is the basis for development of employee wellness programs, in addition to the potential they offer to reduce district health costs by improving the health and fitness of staff members. Wellness programs might include health appraisals for staff members conducted by the school nurse; smoking cessation classes; aerobics and/or other exercise classes; formation of walking/running clubs; and classes on weight control, stress management, or nutrition. Local hospitals, public health agencies, and volunteer organizations will often offer instructors; staff members themselves may be able to provide expertise. In short, employee wellness programs need not be a costly item in the school health program, but they are invaluable in developing good health practices and creating a healthy school environment.

10. ***Plan for evaluation and accountability.*** Determining how effective the district's school health program is will be a factor of the program goals established by the school board early in the planning. What will be measured in terms of knowledge gains and behavior changes will depend on what the school board has identified as the desired, achievable results of the program. School boards will want to assess their school health programs to see if they are really working and to learn what changes are required to meet ongoing and/or anticipated needs. Also, in this time of increased attention to accountability, no program can be sustained without a review of its impact. School boards will need to regularly evaluate whether materials used are interesting and relevant to students and teachers, how parents and the school community are reacting to the program, and how well it seems to be meeting its objectives. In addition to health knowledge gains, indicators of program success include higher morale among students and school staff, reduced absenteeism, decreased needs for emergency medical care, and lower numbers of referrals for discipline problems.

As a result of the overburdened school agenda, many school districts tend to react to crises or mandates rather than taking the initiative in developing solutions to problems. Comprehensive school health programs provide the means to anticipate and address health and learning issues in a systematic way. It is more effective and requires less effort in the long run to take the comprehensive approach. Comprehensive school health programs allow long-range, life-changing effects to take place. They provide the structure for dealing with specific problems as they arise, and they put single issues in perspective. They reduce the frustration caused by trying to deal with multiple problems in the school

environment—increasing numbers of students with poor self-images, school violence, teen pregnancy, drug/alcohol abuse, poor fitness, eating disorders, hunger, and the plethora of other difficulties facing today's students—by providing the framework within which attention can be focused on those issues deemed most critical without losing the overall purpose of improving health and instilling lifelong healthy attitudes and behaviors. Comprehensive school health programs deal with the whole child (physical, intellectual, emotional, and social), providing the knowledge and skills needed to achieve academic success and enhancing the opportunities for healthy, productive lives. ■

BEYOND THE SCHOOL DISTRICT BOUNDARIES

Prince George's County (MD) Public Schools is a large school district encompassing several Maryland suburbs of Washington, DC. The district's 104,000 public school students represent families whose socioeconomic status ranges from lower to middle class. Because statistics reveal that Prince George's County has the second highest HIV infection rate in the state and a substantial alcohol and drug abuse problem, school health programs are a priority for the County School Board.

Faced with education budget cuts, the district has adopted a proactive stance *vis a vis* its efforts to meet the education and health needs of its students. In collaboration with the Maryland State Department of Education and the University of Maryland, the school district has sought and obtained a grant from the US Department of Education to improve and expand the health education component of its school health program. This three-year grant will allow Prince George's County to receive health education training, revise health curriculum and training materials, conduct a wellness conference, and evaluate the effectiveness of health education.

In its first phase of the project, Prince George's County teachers and school staff members will participate in training institutes conducted by the state department of education. Curriculum writing, health instruction, and integration of school health program components are among the training institutes that will be offered. A cooperative effort by the district and the state department of education that will result in a statewide employee wellness conference comprises the project's second phase. Based on the Seaside (OR) Wellness Conference, the Maryland conference will emphasize development of health promotion activities that will improve school staff morale and effectiveness, develop good interpersonal relations, and build positive role models for students. University of Maryland researchers will conduct an evaluation of the conference's effectiveness.

The third element of the grant is local program implementation and evaluation. This is a five-step process involving:

- refinement and adjustment of the district's health curriculum, based on the Maryland curriculum framework;
- provision of inservice training in health education for all health teachers and appropriate staff;
- pre-testing of students in grades K through 12 to determine health knowledge, attitudes, and behaviors;
- implementation of health instruction in grades K through 12; and
- post-testing of students in grades K through 12 to determine health knowledge, attitudes, and behaviors.

This part of the project will be ongoing during the three year grant period. Evaluation will be conducted in conjunction with the University of Maryland.

The district's Health Education Supervisor, Michael Schaffer, stresses the importance of evaluation. In addition to providing data that demonstrate the effectiveness of health instruction—data that is critical to continuing support for school health programs—he notes that, "What gets measured, gets taught."

Through their alliance with the state department of education and higher education, Prince George's County is achieving several objectives:

- improvement and expansion of the district's health education program more quickly and effectively than district resources alone would have allowed;
- provision of teacher and staff training programs that will enhance the health instruction, health services, and school environment components of the district's school health program;
- implementation of health education throughout the district at each grade level; and
- objective evaluation of the validity of the program's framework and the effectiveness of the health education program at each grade level in increasing health knowledge, and changing health attitudes and behaviors.

All of these results have implications for school health programs in other school districts. Replication of Prince George's County's collaborative efforts can provide school boards and school districts with enhanced abilities to sustain and expand their school health programs in times of decreasing education budgets and increasing student needs.

For additional information about the Prince George's County Public Schools' school health programs, please contact:

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CHAPTER VI:

SUCCESSFUL PROGRAMS IN ACTION

APACHE JUNCTION UNIFIED SCHOOL DISTRICT
APACHE JUNCTION, ARIZONA

Location:	40 miles east of Phoenix
Type of District:	Small city
Student Enrollment:	4,000
Number of Schools:	4 elementary schools, 1 middle school, 1 high school
Racial/Ethnic Composition:	94% Caucasian, 6% Hispanic
Students receiving free or reduced price lunch:	45%

Apache Junction, a small city with a population of approximately 23,000, is in one of the poorest counties in the state, with 18 percent of its population living below poverty levels. The school district includes the city and 204 miles of surrounding desert and has a school population that spans the socioeconomic spectrum. The district experiences a 30 percent turnover rate in its student body due to the transient nature of many of its families; a high percentage (35 percent) of Apache Junction students are designated at-risk; the drop-out rate is as high as 50 percent in some parts of the county; and the teenage pregnancy rate is the highest in the state at 22 percent.

Meeting the multiple needs of its students and families in innovative ways has long been the *modus operandi* in Apache Junction. The district's Educational Philosophy best expresses the school community's proactive stance:

> The Governing Board believes that meaningful changes in educational programs, both content and methods, are necessary to meet the expanding needs of our young people as they prepare for the future . . . . We believe that the educational process should develop a feeling of self-worth and accomplishment. Instructional programs in the District should be working in concert to realize this mandate . . . . We [must] work together to help ensure the development of attributes and attitudes required to function in the world of today and tomorrow.

Challenging the district's goal to provide a quality education and opportunity for success to all its students are the statistics listed above. In beating these statistics, high school principal, Dr. Jack Larson, says, "We don't ask 'Can we do it?' but '*How* can we do it?'" It is that determination to overcome the obstacles, to see the challenges as opportunities, that permeates the district's schools and its school health program.

How Apache Junction Began

The evolution of Apache Junction's school health program is filled with human interest stories. Witness Ms. Carmen Huerta, a school bus driver in Apache Junction in the late 1970s. She picked up children along her route day after day, Ms. Huerta became increasingly worried about desperate living conditions and poor health of many of her youngsters. Working first as a volunteer—gathering food and clothing for the homeless and other needy children—Ms. Huerta helped families find places to live, found jobs for unemployed parents, and took children and family members to the doctor.

Committed to providing better lives and opportunities for the at-risk children in the district, Ms. Huerta ran for the local school board, was elected, and served six years. Her volunteer efforts grew and became a formal school district program called Project HELP. Following her service as a school board member, Ms. Huerta joined the district staff as director of Project HELP, a program that has been recognized by the state of Arizona as a model innovative program. Today, Project HELP is one of many programs within the school district that are designed to meet student needs. The dedication and "can do" attitude of Ms. Huerta is emulated throughout Apache Junction's school health program, encompassing the many dimensions of each child.

Planning and Development of the School Health Program

The school board and district administration identified problems that impacted on local schools and used statistical data compiled by the county concerning the educational, economic, and health status—current and projected—in establishing the need for an expanded school health program. This information provided guidance in determining first steps and longer-range issues.

Two factors contributed to the school district's ability to proceed quickly with planning and development: First, good, established communication between the schools and the community, and second, the district's existing holistic approach to education. With need determined and the educational philosophy and goals in place, the school board launched a multi-faceted plan:

- to review existing policies and revise or develop policies appropriate for a comprehensive school health program;
- to select a program coordinator;
- to establish a formal school health advisory committee;
- to develop a health education curriculum; and
- to link health education and services.

The program coordinator's position was assigned to the district's assistant superintendent; his task was to work closely with the curriculum development team, define the relationship between school and community health service providers, and form the advisory committee.

Encouraging Community Involvement

Apache Junction has been able to assemble an advisory committee that is truly community wide. Representatives from health and mental health agencies, social services agencies, government offices, and civic organizations serve on the advisory committee, along with school board members, parents, and teachers. The committee advises the school board on all health education matters and serves as an important link with the community.

A school volunteer program involves retired citizens as tutors and mentors. An active school-business partnership involves local business people:

- as speakers in classrooms;
- as employers of cooperative education students;
- as providers of part-time employment for needy students;
- as mentors for students for a profession or occupation;
- as employers of teachers for two-week periods for occupation updating; and
- as providers of mini-grants for small school projects or workshops.

The community commitment to collaborative efforts is perhaps best expressed by the words of a sixth grade teacher in Apache Junction who says: "If it's best for the kids, we will find a way together to do it."

The Health Education Program: Curriculum Designed to Meet Local Needs

The health education scope and sequence was developed for K through 12 instruction, with curriculum for each level (elementary, middle, and high school) planned by teachers at those levels. Hands-on activities; methods of infusion into language arts, science, and social studies competencies; and staff-developed material were developed to enhance the textbook-based instructional program.

The scope and sequence recommends hours of instruction; however, district policy gives individual schools decision-making authority over how and where to teach health education within the total school program. The average hours of instruction are 18 hours per grade level in grades K through six. In middle school, health education occurs primarily in science classes, with one quarter of the science class time spent addressing issues such as awareness of self, body management, substance use and abuse, HIV/AIDS, and desert survival skills. Health education is also part of home economics and physical education classes. At the high school level, health education and physical education are combined. High school graduation requires one semester of health education and one semester of Success Skills, a course in self-esteem enhancement that uses a curriculum stressing personal and social responsibility. Average hours of instruction in the middle and high school grades are 55 hours per school year.

Supporting Activities and Programs

The Apache Junction School District has instituted several supplementary programs that link health education and school health services. Among the innovative approaches for dealing with comprehensive health issues in the school community are:

- Project HELP, described earlier;
- Home-School Visitor Program—designed to meet the needs of students whose environmental surroundings may affect their general welfare;
- At-Risk Support Programs—which include the following:
  - Mental health and substance abuse counseling for students whose educational achievement is affected by personal or behavioral problems;
  - DARE (Drug Alcohol Resistance Education), a joint effort between the school district and local police in which students are taught by police officers, who have been trained in classroom teaching techniques, to recognize and resist the many pressures influencing them to experiment with drugs and alcohol;
  - Teen Pregnancy/Parenting Program, taught by school nurses and designed to help teens achieve a more self-supporting foundation and increase the quality of their lives; and
  - Parent enrichment classes that provide parenting skills and child abuse prevention techniques.

Two academically-oriented programs have been developed to enhance the health education and health services components of the district's school health program.

- The Alternative School Program was initiated in 1987 for middle and high school students who do not achieve success in the traditional school setting. During the program's third year, student completion rate was 65 percent, with 87 percent of participating students maintaining B/B- averages. Alternative School hours are late afternoon and early evening, allowing the many students who must work and/or raise families to continue their educations. The school is funded through grants.

- The Intervention School is a school-within-a-school, designed for students in danger of dropping out of school. It meets for two class periods during the regular school day. Counseling and tutoring are an integral part of the program, which was piloted in 1990. Students sign a contract concerning objectives and work with a teacher-mentor.

Health Services

Apache Junction's health services component of its school health program is strong. In addition to providing a full range of basic health services, the district gives physical examinations for all athletes. School nurses and counselors provide classroom instruction, assist with inservice training, work closely with public and private health care providers, and assist the Home-School Visitors and HELP Programs. The school nurse:student ratio is 1:444; the counselor:student ratio is 1:666. School health services personnel are supported by 28 physicians, dentists, and social workers who provide services for the district on referral. The extensive health records maintained by school nurses and counselors are the basis for provision and expansion of programs, as well as for evaluation of program effectiveness. Among demonstrated program successes is the continuing decrease in the number of students referred to other health and social service agencies.

The Healthy School Environment

Apache Junction's focus on the whole child is reflected in the school environment. Beyond the well-maintained and visually attractive facilities, food services receive particular attention. With 45 percent of their students participating in free or reduced-price breakfast and lunch programs, food services personnel concentrate on providing nutritional foods that are also appealing. This is not always as easy as it may sound. Many children, unaccustomed to eating a balanced diet, do not like many healthy foods. Coordination between the food services element and the nutritional component of health instruction becomes very important.

Acknowledging the critical function of teachers and school staff, the Apache Junction school board and administration support the wellness of district employees through a variety of health services. Included in the staff wellness program are courses on stress management and development of interpersonal skills. The Communications Management Program is part of the district's career ladder program and is required for all athletic coaches as part of the district's effort to develop self-esteem building techniques. The district's administration attributes some important results to the Communications Management Program: a decrease in teacher turnover from 23 percent in the 1983-84 school year to seven percent in 1989-90; a 100+ point gain in students' standardized test scores in grades one through eight within two years; and increases in middle school students' scores, raising them from the 25th percentile to the 53rd percentile on standardized tests in three years.

Paying for the Program

Apache Junction's school health program is a part of the general school budget. Strong school board and community support for health education and school health services ensures that these needs will continue to be included in budget planning for the district. In addition, program coordinator, Dr. Barry Sutter, actively seeks grants to support the program. Local agencies and organizations also sustain program elements through their dollars and/or in-kind contributions, e.g., the mental health agency provides two mental health counselors. Some dollars also come from community members' contributions and from school staff. For example, teachers from the high school have donated monies for hiring contract tutors for the Intervention School. Lastly, the local school-business alliances continue to be particularly strong patrons of the school health program.

Into the Future

Evaluation of current programs and planning of future programs are ongoing and involve the whole community. A new partnership between a local business and the Alternative and Intervention Schools is being formed. Designated as S.W.A.P., Student Work Achievement Program, this alliance offers incentives and support to students who are in danger of dropping out of school. With a forward-looking

and innovative school board and administration, the school district continues to develop its role as a leader in the community. Why does Apache Junction's school health program work? According to one teacher, ". . .because parents are involved, teachers are respected, and the school board and superintendent talk to and listen to the community." It also succeeds because the school board and administration believe in their abilities to make a difference! By keeping more students in school, and developing their job and life skills, the Apache Junction school board is reaching its long-range goal of improving individual and community opportunities.

For more information about the Apache Junction School District's school health programs, please contact:

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FERGUSON-FLORISSANT SCHOOL DISTRICT
FLORISSANT, MISSOURI

Location:	North of St. Louis, Missouri, in North St. Louis County
Type of District:	Suburban
Student Enrollment:	10,921
Number of Schools:	15 elementary schools, 3 middle schools, 3 high schools, 2 special schools
Racial/Ethnic Composition:	54% Caucasian, 44% African-American, 2% other
Students receiving free or reduced price lunch:	24%

The Ferguson-Florissant School District is a progressive school system and has been at the forefront of planning and implementing many new education programs. A Parent-as-First-Teachers program assists parents from the birth of their children through age three; a Saturday School Program serves four-year-olds; a screening program for three-year-olds identifies at-risk children or children who may be affected by any hinderance to their learning abilities; and four Child Development Centers offer child care services for two-, three-, and four-year-olds on a fee basis. National recognition for Ferguson-Florissant's innovative programs illustrates the school board's and district administration's commitment to educational excellence. In keeping with this history of action and innovation, the district developed its school health program in 1987 and was instrumental in the development of Missouri's Comprehensive Health Competencies and Key Skills, instituted in 1989 by the Missouri State Department of Elementary and Secondary Education.

Beginning the Process

"The mission of the Ferguson-Florissant School District is to produce self-sufficient citizens who are adaptable to change and who possess the self-esteem, motivation, and skills to continue individual growth, solve complex problems, and respect cultural differences."

–Ferguson-Florissant School District Mission Statement

To meet the changing needs and concerns of the school community, the Ferguson-Florissant Board of Education and staff began a strategic planning process in 1986. The objective was to review current programs and develop a five-year plan designed to provide a quality education for all students. The health curriculum was designated to be the focus of review and evaluation in 1987. A review committee composed of administrators, school staff, teachers, and parents examined the status of the health curriculum, health services, and the supporting school environment.

The initial recommendations of the review committee were three-fold:

- to revise the health education program to ensure coordination between grade levels;
- to begin institution of a comprehensive, sequential K through 12 instruction program; and
- to include all health topics, as addressed in the health education mission statement, in the district's educational outcomes statement.

The long-range plan for the school health program includes curriculum development and implementation, staff development, and health services. Incorporated into the health services category are healthy school environment and community involvement components.

Assessing the Need and Developing the Goals

To begin, parents, students, and teachers were surveyed to obtain their opinion of the current health education program and the need for additional instruction. Survey questions varied depending on grade level (elementary, middle, high school) and respondent (student, parent, school staff). In addition to this internal review, an external review committee was formed, including representatives of higher education institutions, county health service agencies, health-related organizations, and curriculum specialists, to evaluate the proposed revised program and offer recommendations for further improvement.

In concert with the review and assessment processes, the school board adopted a program philosophy, a goals statement, and a school health programs mission statement. These documents have served as affirmation of the school board's commitment to the school health program.

That Special Someone

With these guidelines in place and with school board approval to institute a school health program, the district selected and assigned a program coordinator who devotes 40 percent of her time to program development, management, and evaluation. The responsibilities for the Ferguson-Florissant school health program coordinator include:

- oversight of and responsibility for the school health program, including instructional health services and a healthy school environment;
- assistance to classroom teachers in correlating health instruction with other subjects;
- liaison with various health and other concerned agencies, both public and private, in coordinating and implementing the health services offered to students in the public schools; and
- evaluation of the school health program and recommendation of appropriate revisions to program components, based on assessed program effectiveness.

The School Health Advisory Committee and the Community

Ferguson-Florissant's Advisory Committee includes teachers and school health services staff, parents, students, public health officials, clergy, and representatives from community-based organizations. The broad-based council has facilitated development of community support and coordination with other community service groups and businesses. Among the many school-community alliances that have formed is the school-business partnership, from which an impressive list of joint activities has developed. The list includes:

- student training
- mentoring programs
- surplus equipment donations
- reciprocal inservice training arrangements
- workshops in areas of expertise
- classroom presentations
- technical assistance for projects

The School Health Program

The Instructional Component. Health instruction is provided as a stand-alone course in middle and high school grades and is integrated into other curricula in the elementary grades. Health education is also integrated into science, language arts, physical education, and other courses at various grade levels. Hours of instruction provided are: K through six, 10 hours required with an additional 10 hours optional; grades seven and eight, 22 hours required; grade nine, 45 hours required; grades 10 through 12, 45 hours optional.

Inservice training programs are provided for everyone teaching health education in Ferguson-Florissant. At the elementary level, one teacher from each grade level at each school attends the training programs. A "professional credit incentive" of $50 that may be applied to the purchase of health materials is given for providing inservice to the other teachers in the appropriate grade level. These credits can be, and have been, consolidated for an entire school. The district has found this method of offering incentives to be successful in both motivating teacher participation in training and in supplementing curricular materials. Elementary classroom teachers all complete a methods class in health education and receive instruction on how to integrate health education into other subject areas. At the middle school and high school levels, all teachers have a computer disk containing student study guides that can be printed out and distributed to students. The study guides, containing a listing of the topics to be covered, readings, resources used and learner outcome statements, were written by teachers representing each of the schools.

Support Activities. Ferguson-Florissant's school health programs reinforce health education. Examples of the activities and programs that support the instructional program are:

- DATE (Drug, Alcohol, Tobacco Education)—a nonprofit, Missouri-based organization that provides speakers and prevention-oriented materials.

- Drug Intervention—In 1984, the district initiated a drug intervention program in conjunction with a local hospital for students who have been suspended from school for a drug or alcohol violation. During the first year of operation, 53 referrals into the program were made; in the 1989-90 school year, only 10 students were placed in the program. Students maintain their academic program while in treatment and receive counseling services, some jointly with their family members.

- Guidance Program—A new proactive comprehensive guidance program has been introduced at Ferguson-Florissant. School counselors not only are assigned to handle student problems and crises, but are required to teach various classes at all grade levels. These classes include self-knowledge and understanding of others, development of positive self-image, and understanding of the effects of drugs and alcohol.

- Wellness Profile—Each year, in the Fall and the Spring, every student is given a series of physical fitness tests. Physical education classes are planned to improve the students' basic scores, and students are encouraged to set their own goals for improvement. PE instructors report that the profile has generated high student interest in fitness and has resulted in improvements in physical abilities.

- Conflict Resolution—Middle school students participate in a conflict resolution program called RAPP, Resolve All Problems Peacefully.

- PRIDE (Punctuality, Respect, Integrity, Discipline, Esteem)—Developed by parents, students, and teachers, the PRIDE program is designed to help young people cultivate positive character traits.

- Annual Walk-Run Event—A community-wide health event, the Walk-Run occurs every Spring. This popular activity has several categories of competition for various age groups, and generates revenue for the district at the same time that it promotes health.

The Health Services Component. Health services are addressed in the school board's Policy #2072: " The health of all pupils and employees is of vital concern to the school district. School nurses are employed full time for the purpose of promoting healthful conditions in the schools. In addition to carrying on duties relating to health examinations, inoculations, first aid, safety, quarantine, etc., school

nurses may assist in the health instructional program. They advise [instructors] concerning materials and resources and also counsel students about health matters. School nurses sometimes make home visits as needed for follow-up of a school or individual health problem."

Health services provided directly to students include inoculation checks, vision and hearing screenings, speech therapy, physical examinations, counseling, and a drug intervention program. (The ratio of school health professionals to students is 1:214.) The drug intervention program and guidance program mentioned above are examples of ways in which Ferguson-Florissant has integrated its school health education and services components. School counselors and nurses maintain liaisons with community social services and work directly with caseworkers in providing services to individual students. The substance abuse program coordinator also works closely with the juvenile courts.

The Healthy School Environment Component. In addition to careful attention to the physical environment of its school buildings and grounds, administrators, teachers, and school staff are viewed as important role models in Ferguson-Florissant. Several schools offer a number of employee wellness programs, including weight control, smoking cessation, and exercise classes. Teachers in one school have engaged in a "tonnage toss" weight loss program. Food services are afforded special attention. School meals are varied and nutritious, reinforcing the nutritional lessons taught in classrooms. In 1990, salad bars were added to several lunchrooms.

Ferguson-Florissant provides some excellent examples of ways in which a school district can integrate its health program with other school and/or school-community activities. In addition to ones already mentioned, the district cooperates with the American Heart Association's annual Jump Rope for Heart program, conducts a Walking Wellness workshop, and provides parent support groups.

How Do They Do It? The Budget

In Ferguson-Florissant, good planning was the key to setting the budget. The program planners developed two sets of figures for school board consideration: (1.) How much was being spent for what in terms of school health education and services at the time, and (2.) What would be needed to accomplish the goals established. A five-year budget plan provided the means for spending available dollars where they were needed in order to maintain, improve, and expand the program.

Currently, the overall curriculum budget provides most of the funding for the health education curriculum in the district. The building budgets, administered by the building principals, are used to support workshops and training. In addition to the $25,000 allocated for health education by the district, some monies are derived from grants, including Drug Free School and Communities grants for teacher training and curriculum development. Local alliances, such as the school-business partnership, provide invaluable in-kind support for the school health program.

Onward and Upward

Collection of evaluation data concerning program results is being planned by the district. Like many school districts, Ferguson-Florissant struggles to find appropriate means for measuring the outcomes of health programs. Objective data are available in the schools' health records (figures concerning absenteeism, numbers of specific physical and psychological health problems), as well as through the Wellness Profiles which track a student's physical fitness throughout his or her school years. Subjective information has been provided by teachers and staff members who report observed changes in students' personal hygiene, increased interest in physical fitness, and more realistic values.

General plans call for measuring program effectiveness by ongoing monitoring of objectives, periodic surveys of teachers, students, and parents relating to perceptions about the program, responses from parent and citizen advisory councils, and through more formal internal and external reviews and studies.

The more formal procedures will be conducted every five years and results will be used in developing the next five-year plan.

The lesson from Ferguson-Florissant is that good planning results in implementation. School health program coordinator, Joyce Espiritu, stresses that it is better to begin by doing what is possible. Comprehensive school health programs, once begun, tend to win converts to good health and its importance to all other undertakings. It is often the ideas and enthusiasm of those who have come to support the working programs that provide revisions and new concepts leading to a truly effective comprehensive school health program.

For more information about the Ferguson-Florissant School District's school health program, please contact:

Ms. Joyce Espiritu
School Health Program Coordinator
Ferguson-Florissant School District
1005 Waterford Drive
Florissant, MO 63033
(314) 831-4411

HOLYOKE PUBLIC SCHOOLS
HOLYOKE, MASSACHUSETTS

Location:	**Western Massachusetts, on the Connecticut River**
Type of District:	**Urban**
Student Enrollment:	**7,500**
Number of Schools:	**10 elementary schools, 3 middle schools (including 1 magnet middle school), 2 high schools, 1 vocational-technical high school**
Racial/Ethnic Composition:	**63% Hispanic, 32% Caucasian, 4% African-American, 1% Asian**
Students receiving free or reduced price lunch:	**63%**

Holyoke, Massachusetts, is an old New England manufacturing town whose companies have moved, leaving the city with no supporting industry, a declining economy, and escalating health and social service needs.

Concern about the district's high teenage pregnancy rates (number one in the state in the mid-1980s) and increasing substance abuse among children and adolescents prompted initiation of a school-parent-community alliance to confront and solve these problems. In deciding where to start, Holyoke High School principal Edward Shevlin says, "We wanted to know what the greatest needs were, so we began by asking the kids why they were absent [from school]. We checked the medical insurance coverage available (or, really, not available) to our students. The needs were revealed."

The Holyoke Planning Process

This direct approach resulted in quick action in the school district. Establishing an advisory council of those teachers, parents, local doctors, and school nurses who had expressed interest, the district appointed staff member Elizabeth Bradley as Director of Health, and began planning. Holyoke's strategy was to:

- determine the nature and extent of the issues to be addressed;
- develop clear, concise policies concerning program implementation procedures, review standards, fair and firm enforcement, and communication;
- plan interaction among the school health program components (instruction, health services, and school environment); and
- provide training to teachers, school staff, parents, and the community.

With school board support, the advisory council developed a curriculum to meet local needs. Essential in Holyoke was the preparation of all materials in a bilingual format to meet the needs of Hispanic students.

Community Involvement

School district-parent-community collaboration is the thread that runs through Holyoke's school health program. The School Health Advisory Council includes students and representatives from some 20 community-based organizations. The Council reviews the health education program goals and budget, and presents its recommendations to the school board. In addition, the district has formed both a Holyoke Primary Care Task Force that is specifically concerned with the health and education needs

of the large bilingual population, and a School Health Services Committee that attends to elementary school student needs. Parents serve on a city-wide Parent Planning Council, addressing health and education policy. Parent Advisory Councils and School Improvement Councils are organized at every school building. A Parent Information Center offers translations, transportation, and child care services, and maintains a full-time parent coordinator. Handbooks, brochures, and manuals for parents about school health programs have been developed in both English and Spanish. Programs for parents include classes on nutrition, parenting skills, and literacy, along with activities intended to promote self-esteem.

The Health Education Curriculum and Training Component

In addition to developing a curriculum that would be comprehensive, sequential, and appropriate for each grade level, K through 12, the initial advisory council wanted to provide teachers with materials that could be used right away in the classroom. Holyoke's "Ready-Set-Go" curriculum and supporting materials give teachers lesson plans complete with suggested activities, ready-to-copy worksheets and games, teaching techniques, and referrals to additional resources. Program coordinator, Elizabeth Bradley, believes that this "user-friendly" curriculum has allowed a much quicker implementation of health instruction into the district's classrooms.

Hours allotted to health education in the Holyoke Public Schools are as follows:

grades K-5	36 hours per year
grades 6-8	10 weeks; actual hours vary from 30 hours per year to 50 hours per year
grade 9	90 hours per year, with health instruction presented every other day for the entire school year
grades 10-12	HIV/AIDS education classes

Health education is a graduation requirement.

Reinforcing Programs and Activities

Holyoke's supporting programs and activities promote the preventive focus of the school health program and emphasize self-esteem. These include:

- DARE (Drug and Alcohol Resistance Education), conducted in cooperation with the Holyoke Police Department, and "Mr. No-No" programs that deal with substance use and abuse;
- ALATEEN, in cooperation with Alcoholics Anonymous, for children of alcoholics;
- Parenting classes for pregnant and parenting adolescents; and
- A child care center for adolescent parents, developed to encourage teenage mothers to return to and stay in school.

Health Services in Holyoke

The school district provides all the basic health services to its students—immunization checks; vision, hearing and dental screenings; speech therapy; and counseling. Physical evaluations are given at grades four, seven, and 11, as well as throughout the year at the Teen Clinic. Physicals for athletes are conducted quarterly with a trainer and a volunteer pediatrician. There is a school-based clinic at one high school, with additions planned for the second high school and the middle schools. Clinic services are available year round. Eight school nurses and 18 guidance counselors, including four guidance counselors for special needs students, provide health services to the district's 7,500 students.

The Teen Clinic

The Teen Clinic's mission is to provide comprehensive primary preventive care, acute medical and mental health care, and health education services to the school population in Holyoke. The Teen Clinic is a cooperative effort of the Holyoke Public Schools, Holyoke Pediatric Associates, the Department of Public Health, and the River Valley Counseling Center.

The clinic provides physical examinations, treatment for minor illness, laboratory tests, immunizations, as well as on-site counseling for personal hygiene, alcohol and drug abuse, family and relationship issues, and specific health-related problems. These services are provided by a pediatric nurse practitioner, a physician's assistant, and a pediatrician with medical backup from Holyoke Pediatric Associates and the Holyoke Health Center.

The Teen Clinic won rapid acceptance from students and their parents. Three-fourths of the Holyoke public school students have signed parental permission slips to use clinic services, and over half of the students made use of the clinic during the 1989-90 school year. The existence of the Teen Clinic and its cooperative efforts with supporting agencies are beginning to show results: student visits to emergency room facilities are decreasing—saving taxpayer dollars and insurance costs—and 40 percent fewer pregnancies occur among adolescents age 16 and below. Community health professionals and educators in Holyoke believe that services, combined with health education, have contributed significantly to improved health among students, reduced risk-taking behaviors, and increased student attendance and graduation rates. Additionally, program supporters note, an unknown number of dropouts are prevented by the availability of health services that are provided in an atmosphere of care and concern for the whole child.

The Healthy School Environment

The Holyoke school board and administration are committed to creating and maintaining a high level of satisfaction, morale, and health among Holyoke Public School students and staff. Positive role modeling is stressed, along with good interpersonal relations. Promoting self-worth and self-confidence in both students and their adult teachers and guides is a primary goal within the school system.

Two highly visible examples of efforts to promote good health and healthy lifestyles for everyone are the employee wellness program, currently under development, and the smoking cessation program, conducted in cooperation with the American Lung Association. The interaction between health services and health education, vigorously promoted by the school board, promotes a healthy school environment and results in a potent force for healthy lifestyle choices.

Finding the Dollars

The general education budget in Holyoke provides for health education curriculum and teacher training, as well as basic health services. The in-kind contributions of staff time, supporting materials, and other services of those organizations and agencies working in alliance with the school district to improve student health, in many ways, enable it to maintain programs and services. The school-community coalitions in Holyoke are a testimony to the importance of forming cooperative agreements to program success, particularly in times of budget constraints.

Holyoke program personnel aggressively solicit state, federal, and private foundation grants as they become available. Additional revenue is anticipated from the licensure of the Teen Clinic by the Massachusetts Department of Public Health. As a licensed, free-standing medical clinic, the Teen Clinic will have the ability to direct bill third party insurers, including Medicaid. Reimbursement for medical services will allow the clinic the future support needed to continue its crucial operations and permit

further achievement along the road to the district's ultimate goal: to provide its students the opportunity for healthy lives, academic achievement, and success.

Future Plans

Good school health programs are always future-oriented, and Holyoke is certainly no exception in this regard. While planning for the expansion of health services, addition of new employee wellness programs, and continuing revisions of the health education curriculum and updating of teacher training, the district is anticipating future needs and implementing the programs to meet them. Among the 1990-91 goals set for the school health program are:

- development and implementation of an HIV/AIDS education inservice program for teachers and school staff;
- implementation of Kids & Company, Together for Safety, a child safety program being developed with a corporate grant;
- implementation of an evaluation component in cooperation with the New England Health and Poverty Action Center at Tufts University; and
- formulation of a smoking cessation program for students.

The Holyoke Public Schools' school health program continues to build on its strengths—strong school board support; community recognition of and commitment to the importance of school health programs; a dedicated program coordinator; a good curriculum that meets the students' needs; extensive and individually-tailored health services; multiple supporting activities; and a plan for the future.

For more information about the Holyoke Public Schools school health program, please contact:

Ms. Elizabeth J. Bradley
Director of Health
Holyoke Public Schools
Holyoke High School
500 Beech Street
Holyoke, MA 01040
(413) 534-2020

DALLAS INDEPENDENT SCHOOL DISTRICT
DALLAS, TEXAS

Location:	North Central Texas
Type of District:	Urban
Student Enrollment:	134,000
Number of Schools:	137 elementary schools, 25 middle schools, 20 high schools, 16 other schools, including special education schools, magnet schools, and alternative programs
Racial/Ethnic Composition:	47% African-American, 33% Hispanic, 18% Caucasian, 2% Asian/Native American
Students receiving free/reduced price lunch or breakfast:	73% lunch, 92% breakfast

The Dallas Independent School District's (DISD) educational philosophy is expressed by a sign that greets everyone entering Carr Elementary School in Dallas: "We can teach all children."

While DISD students bring a multitude of positive and negative behaviors, attitudes, backgrounds, and problems to school with them, the primary issues of concern for Dallas health educators are HIV/AIDS and urban violence. The comprehensive school health program that has been developed and is evolving permits emphasis on these current critical needs and, at the same time, provides a solid health education base to students. DISD's program emphasizes enhancing self-esteem, developing decision-making skills that affect all of one's life, and providing every opportunity for success.

Developing the Program

Beginning in the 1970s with a health education focus on high teenage pregnancy rates, premature births, and their implications for lifelong health education, Dallas' school health program expanded to a comprehensive program. By concentrating on a limited number of problems, the school board and administration were able to assess their needs quickly, identify available resources, and undertake cooperative efforts to address the most important issues first. By establishing attainable goals, they avoided a common mistake, i.e., raising expectations beyond what can realistically be accomplished. The reasoned approach to school health in Dallas assured their success.

A needs assessment was conducted to determine what existing programs and services were provided and what was perceived as required to meet actual needs. Assessment surveys concerning policies, administration support, health services, health instruction, physical education, counseling and guidance, food services, school-community interaction, and employee wellness were given to school personnel, parents, and community members and organizations.

The Community Role

Dallas school board members stress the importance of involving the community in the school health program from the beginning. Two examples of community involvement in Dallas are the collaborative efforts of the Dallas Police Department and the medical profession with the schools. Through classroom instruction, police officers interact with students to help them develop their personal and social skills in resisting pressure to use alcohol or drugs, and make responsible decisions about risky behaviors. Additionally, the police department personnel serve as advisors to the school district on the subject of cults: how to recognize and deal with them. Private medical practitioners offer preventive health care services to students, serve as medical consultants for the district, and meet special needs, such as

providing eyeglasses to needy students. The Dallas Medical Society has underwritten the costs of distributing HIV/AIDS education materials. A dental care program involving private dentists is in the planning stages.

The School Health Advisory Committee is actively engaged in ongoing program reviews and recommends program and policy revisions. Composed of parents, teachers, students, public health officials, and representatives of community-based organizations, the committee's current focus is HIV/AIDS education.

Health Education in DISD

Health education is clearly defined in a five-point statement of program expectations that reflects the primary goal of giving students the knowledge and skills needed for healthy lifestyles:

1. Provide instruction about health issues.
2. Encourage good decision-making skills.
3. Motivate interest in personal health maintenance.
4. Develop awareness of measures to improve personal health.
5. Activate an awareness of community health agencies that assist in health promotion.

In grades K through seven, health is taught in conjunction with the science curriculum. DISD personnel believe that the science-health linkage is especially effective, giving health greater emphasis as a core subject and reinforcing both subjects by making them interactive. A special workshop on linkage is provided for teachers.

High school health is a one-semester course offered in grades nine through 12, and is required for graduation. Instructional time requirements for subjects have been eliminated in DISD and replaced with outcome-based requirements. DISD recognizes current student needs, and includes additional health concepts that are germane to Dallas students. Subjects included in the health curriculum are personal health and fitness; mental health; human growth, development, and sexuality; environmental health and safety; drug education; nutrition; disease prevention, including sexually transmitted diseases; and health careers. The curriculum emphasizes problem-solving, critical thinking, and coping skills.

A variety of curricula are used and supplemented by materials, equipment, and activity sheets available to schools through the district's Science and Health Resource Center. Human Growth, Development and Sexuality, a locally-developed curriculum, is presented to students in the fifth, seventh, and high school grades. A twenty-four hour training course is provided to teachers by a district instructional specialist and is required before curriculum materials are released. Parent workshops explain the sexuality unit and provide study booklets, entitled "Talking Together," for parents to use at home with students. Ninety-nine percent of the student body are enrolled in Human Growth, Development and Sexuality classes. The parents of the one percent not participating receive home study booklets, entitled "Studying Together." HIV/AIDS education classes are part of the regular course of study, as are drug education and CPR training.

The district's Office of Drug Programs has developed and implemented programs that are integrated into the health curriculum by providing age-appropriate, skill-based instruction that gives students the information and skills they need to resist drug involvement and prepare them to reach their individual potentials.

Incentives for health education inservice training include credit that is applied to the career ladder program and to continuing education. In addition to inservice workshops conducted throughout the year, the program coordinator and the health education specialists work closely with community health

agencies to provide current health information and teaching materials for teachers, available through the Science and Health Resource Center. The coordinator and specialists regularly observe classroom teaching, assist with in-class instruction for teachers who need help, and play a key role in the development and refinement of the curriculum.

In its efforts to link all the components of its school health program, DISD has paid special attention to stressing physical fitness and the development of good health practices in its physical education classes. DISD has developed an Academic Sportfolio that integrates sports and dance with language, math, social studies, science, and art. The program was piloted in four elementary schools and four middle schools during the 1990-91 school year. The math section of the Sportfolio for grades three and four is included as an example, following the Dallas program description.

Health High School

A special element of Dallas' health education program is the High School for Health Professions(HSHP). HSHP serves as a combination of a comprehensive high school and career development center, specializing in health-related professions. The 750 HSHP students must complete all courses required in comprehensive high schools and are offered a variety of advanced classes, including calculus, advanced placement (AP) English, AP U.S. history, AP chemistry, AP biology, Latin, Spanish, French, speech, psychology, and practical law. Health specialties include: bioscience for pre-med, pre-dental, and pre-veterinarian students, dental technology, medical assistance, hospital administration, food management and production, and vocational nursing.

The success of HSHP is attested to by its statistics. In the 1989-90 school year, ninth grade students scored 95 percent in reading, 92 percent in math, and 94 percent in writing on the state tests. Of the 144 graduates of the class of 1989, 60 percent have continued their education, and 22 percent are employed in medical positions.

Supporting Programs

Among the resourceful activities DISD has implemented to augment the school health program and make it more germane to students are:

- Allied Youth—a peer education program through which high school students interact with elementary students, making presentations and holding discussions concerning drug use, violence, gangs, and other issues;

- SAVE (Students Against Violence to the Earth)—an activity that develops awareness of environmental health, civic responsibility, and skills for cooperative efforts and community interaction;

- PASS (Pupil Assistance and Support System)—a crisis intervention program in which school-based teams, composed of administrators, counselors, psychologists, nurses, and teachers, work one-on-one with at-risk students to improve self-esteem and develop coping abilities;

- LETS (Law Enforcement Teaching Students)—a cooperative program with the Dallas Police Department that brings police officers into the classroom and involves them in development of the teaching materials used; and

- STARRS—a no-smoking peer education program conducted for fifth graders that uses a Dallas Maverick's video and intensive classroom interaction.

Health Services

School health personnel work together with students, parents, teachers, and other school and community professionals to promote student achievement. The DISD school health staff includes a full-time medical director, nurse practitioners, registered nurses, and nurse's assistants. Health room volunteers assist the staff at several schools. One hundred forty school nurses and 279 guidance counselors serve Dallas students. School nurses utilize each student contact as an opportunity for health education, and they serve as resource persons to classroom teachers. Health services include basic screenings, evaluating special health needs, administering prescribed medications, and providing first aid and physical evaluations of eligible students.

Teen Clinics

The district has three school-adjacent clinics and one school-based clinic. The Teen Clinics have become part of the county medical system, and both clinic staffs and the district superintendent, Dr. Marvin Edwards, attribute their continuing success to their "free-standing status." Although the clinics are located adjacent to school campuses, they have a separate identity and have come to be seen as community-oriented primary care facilities.

The clinics provide immunizations, operate class D pharmacies and small laboratories, provide physical examinations and pregnancy/parenting care and counseling. Clinic staffs include social workers. Clinic funding comes from state and federal grants, private foundations, hospital taxes, and charges to Medicaid, with some monies derived from patients based on a sliding scale determined by ability to pay.

An innovative program being conducted by one school clinic is "Healthy Tomorrow," a program designed to address the needs of 10-year-olds. The number of contacts with this age group and types of care needed will be tracked. An integral part of the program is development of a parent education component. Working closely with the school nurses, "Healthy Tomorrow" is one of the ways in which DISD is coordinating programs and planning for the future.

Clinic staffs report reductions in pregnancies and fewer younger pregnancies during the past couple of years. Repeat pregnancies are also about seven percent lower than in previous years. They also report that instances of child abuse and homicides are increasing: trends that have implication for the health instruction component of Dallas' school health program.

Medical personnel at the school clinics offer advice concerning the most important element for clinic success: Establish rapport with the surrounding community and school personnel; you are all working to support the same clientele—the students. They also stress the importance of being realistic about the support and funding available. Operating a full-service clinic in an urban community is an expensive venture (about $400,000 annually in Dallas), but the cost can be balanced against student and community needs and dollars saved by the school district in improved student health.

The School Environment

Principals and teachers throughout the Dallas school system speak about the importance of providing a secure place and positive learning environment for their students. They recognize that the school is the only place where many children are physically and emotionally safe. The school board and administration are cognizant of the importance of offering the same support for school personnel, both for the employees' benefit and as a means of encouraging good role models for students. Employee Wellness Programs have been designed to meet the needs and requests of school staffs. Programs include such activities as smoking cessation classes, aerobic/exercise classes, Employee Wellness Fairs which

provide blood pressure and blood cholesterol checks, weight loss programs, and advice concerning health issues. CPR training is also available to all district employees. While suffering major budget reductions, DISD is attempting to maintain those programs promoting health and healthy behaviors among school staffs.

The All-Important Budget

Supporting a school health program of the magnitude required in a major urban school setting is a worthwhile, even necessary, task. It is also costly. DISD budgets $190,000 for its health education program, exclusive of teacher salaries and local school contributions.

The state of Texas provides textbooks; Centers for Disease Control and the Drug-Free Schools and Communities grants have allowed development and implementation of the HIV/AIDS education and drug education components; foundation grants and local contributions, both in dollars and in-kind assistance, permit maintenance and expansion of special programs. Public health and mental health monies help with health services. All in all, in Dallas, as everywhere, the school health program is possible because of good planning and intensive collaborative efforts on the part of the district and the community.

Into the 1990s

DISD is well-situated to face the challenges of the future. Their solid planning base, strong school board support, a trained and enthusiastic health education teaching staff, a skill-based curriculum, program emphasis on decision-making skills aimed at altering negative behaviors, and an evolving evaluation system are among the strengths of the Dallas school health program.

Near-future plans include evaluation of the effectiveness of the program to be conducted by an outside auditing agency. Student surveys and staff interviews will be part of the evaluation to ascertain knowledge gains and changes in risk-taking behaviors among students who have had health education. Among issues that are slated for consideration by program staff and advisory committee members are:

- ways to deal with the increase in teenage gangs and their effects (The school district and the city have formed task forces to look at the impact of the growing numbers of gangs, up from 30 to 300 in two years.);
- how to meet the constant demand for teacher training due to turnovers; and
- classroom surveys to identify needs and interests specific to students in grades four to six.

School and community leaders in Dallas have been successful in providing a model school health program for their students. Their foresight and continuing commitment to school health as a priority will help ensure that the education and health needs of Dallas' children are met today and in the future.

For more information about the Dallas Independent School District's school health program, please contact:

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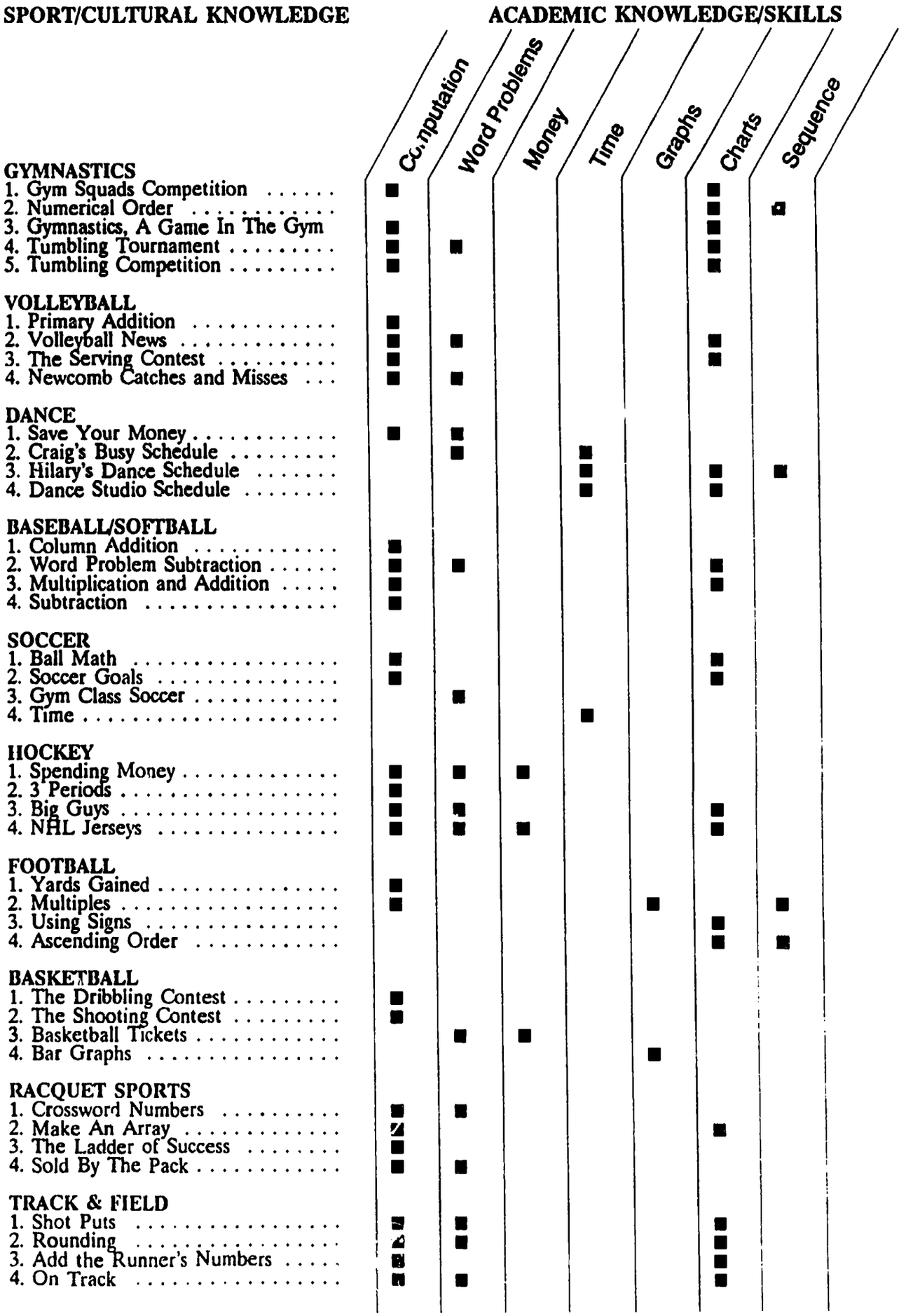
Dallas Independent School District
3700 Ross Avenue
Dallas, TX 75204
(214) 824-1620

GRADES 3 - 4

MATH



CHAPTER VII

RESOURCES

Supporting Organizations

This resource list is intended to provide school leaders with the names of groups and organizations that can answer questions and offer advice and guidance concerning the development and implementation of school health programs. Additionally, many organizations have printed materials, audio-visuals, and program packages available to augment school health education. This is not an all-inclusive list, nor are the organizations, materials, or programs endorsed by NSBA.

American Academy of Pediatrics
Section on School Health
141 Northwest Point Boulevard
PO Box 927
Elk Grove, IL 60007
312-228-5005

American Association of School Administrators
1801 N. Moore Street
Arlington, VA 22209
703-528-0700

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329
404-329-7719

American Dental Association
Bureau of Health Education and Audio Visual Service
211 E. Chicago Avenue
Chicago, IL 60611
312-440-2865

American Federation of Teachers
555 New Jersey Avenue, NW
Washington, DC 20001
202-879-4490

American Heart Association
National Center
7320 Greenville Avenue
Dallas, TX 75231
214-706-1356

American Lung Association
1740 Broadway
New York, NY 10019-4374
212-325-8728

American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
312-645-5315

American Red Cross
National Headquarters
1709 New York Avenue, NW
Suite 208
Washington, DC 20006
202-662-1580

American School Food Service Association
1600 Duke Street
7th Floor
Alexandria, VA 22314
800-877-8822

American School Health Association
7263 State Route 43
PO Box 708
Kent, OH 44240
216-678-1601

Association for the Advancement of Health Education
1900 Association Drive
Reston, VA 22901
703-476-3437

Center for Population Options
1025 Vermont Avenue, NW
Suite 210
Washington, DC 20005
202-347-5700

Centers for Disease Control
Division of Adolescent and School Health
Bldg. 3, B15, MS A-14
1600 Clifton Road, NE
Atlanta, GA 30333
404-639-3824

Council of Chief State School Officers
400 N. Capitol Street, NW
Suite 379
Washington, DC 20001
202-393-8159

Education Development Center, Inc.
55 Chapel Street
Newton, MA 02160
617-969-7100

National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
703-684-4000

National Alliance of Black School Educators
2816 Georgia Avenue, NW
Washington, DC 20001
202-483-1549

National Association of Elementary School Princip
1615 Duke Street
Alexandria, VA 22314
703-684-3345

National Association of School Nurses
PO Box 1300
Scarborough, ME 04074
207-883-2117

National Association of Secondary School Principals
1904 Association Drive
Reston, VA 22091
703-860-0200

National Dairy Council
6300 North River Road
Rosemont, IL 60018
708-696-1020

National Education Association
NEA Health Education Network
1590 Adamson Parkway
Suite 206
Morrow, GA 30260
404-960-1325

National Health/Education Consortium
Institute for Educational Leadership
1001 Connecticut Avenue
Suite 310
Washington, DC 20036
202-822-8405

National Health Information Clearinghouse
Box 1133
Washington, DC 20013
800-336-4797

National Heart, Lung, and Blood Institute
National Institutes of Health
Federal Building, Room 6A-12
7550 Wisconsin Avenue
Bethesda, MD 20892
301-496-3503

National Highway Traffic Safety Administration
400 7th Street, SW
NTS-21
Washington, DC 20590
202-366-2721

National PTA
700 N. Rush Street
Chicago, IL 60611
312-787-0977

National School Health Education Coalition
PO Box 515664
Dallas, TX 75251-5664
214-233-9305

President's Council on Physical Fitness and Sports
450 5th Street
Suite 7103
Washington, D.C. 20001
202-272-3424

The Support Center for School-Based Clinics
5650 Kirby Drive
Suite 203
Houston, TX 77005
713-664-7400

Texas Comprehensive School Health Initiative
Texas Association of School Administrators
406 E. 11th Street
Austin, TX 78701-2617
512-477-6361

US Public Health Service
Public Affairs Office
Room 717-H
200 Independence Avenue, NW
Washington, DC 20201
202-245-6867

Washington State Apple Growers Healthy Choices for America
190 Queen Anne North
Seattle, WA 98109-4924
206-285-5522

AND DON'T FORGET YOUR:

State School Boards Association
State Department of Education
State and Local Departments of Health
Community-based organizations and civic groups

Supporting Literature

The following list contains references that may serve as useful tools in the planning, development, implementation, and evaluation of school health programs. It is neither all inclusive, nor does inclusion here imply endorsement by NSBA.

General

National School Boards Association (NSBA). *Reducing the Risk: A School Leader's Guide to AIDS Education, 1990.*

NSBA. *Building Character in the Public Schools, 1987.*

NSBA. *Alcohol and Drugs in the Public Schools: Implications for School Leaders, 1988.*

American Association of School Administrators. *Why School Health?* Arlington, VA: American Association of School Administrators, 1987.

American School Health Association. *School Health—A Healthy Child: The Key to the Basics.* (A Kit for School Health Planning Groups.)

National Health/Education Consortium. *Symposium Proceedings: Crossing the Boundaries Between Health and Education.* Washington, DC, 1990.

National Health Information Clearinghouse. *Common Questions and Answers Regarding School Health Education Program Development and Improvement, 1984.*

US Department of Education, Office of Educational Research and Improvement. *Health and Physical Education Programs that Work: A Collection of Proven Exemplary Educational Programs and Practices in the National Diffusion Network.* Washington, DC: US Department of Education.

US Government Printing Office. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington, DC: US Government Printing Office, 1990. Superintendent of Documents, US Government Printing Office, Washington, DC 20402.

School-Based Clinics

Albert, KM. "School-Based Adolescent Health Programs: The Oregon Approach." *Innovations*, October, 1989. Council of State Governments, Iron Works Pike, PO Box 11910, Lexington, KY 40578-9989.

Hadley E.M., et al. *School-Based Health Clinics: A Guide to Implementing Programs.* Washington, DC: Center for Population Options, 1986.

Center for Population Options. *The Facts: School-Based Clinics.* Washington, DC: Center for Population Options, 1987.

Evaluation

Booklets on Evaluation of Physical Fitness, Diabetes, Stress Management, Alcohol and Substance Abuse, Smoking, Nutrition, and Immunization Programs. US Department of Commerce, Springfield, VA 22161.

California Department of Education. *Criteria for Evaluating the School Health Education Program.* Sacramento, CA: California Department of Education, 1977.

Metropolitan Life Insurance Company. *"Health: You've Got to be Taught," an Evaluation of Comprehensive Health Education in American Public Schools, 1989.* Health and Safety Education Director, Metropolitan Life Insurance Company, One Madison Avenue, New York, NY 10010-3690.

Nelson, S. *How Healthy is Your School?* New York: NCHE Press, 1986.

Pennsylvania Department of Education. *Health Education Assessment Handbook.* Harrisburg, PA: PA Department of Education, 1990. PA Department of Education, 333 Market Street, Harrisburg, PA 17126-0333.

Health Services

American Academy of Pediatrics. *School Health—A Guide for Health Professionals.* Elk Grove Village, IL: American Academy of Pediatrics, 1987.

US Department of Health and Human Services. *Guide to Clinical Preventive Services.* Washington, DC: US Preventive Services Task Force Report; US Department of Health and Human Services, 1989.

School/Community Alliance

NSBA. *Bridging the Gap: Involving Older Volunteers in the Public Schools,* 1990.

NSBA. "Profiles in Excellence: Parent Involvement," *The Executive Educator,* February, 1991.

NSBA. *First Teachers: Parental Involvement in the Public Schools,* 1988.

Levy, Janet E. *Joining Forces.* Program Promotes collaboration between education and social welfare agencies. Information on strategies and programs for successful collaboration. Janet E. Levy, Program Director, CCSSO, 400 N. Capitol Street, Suite 379, Washington, DC 20001, 202-393-8159.

Mason, J.O. "Forging Working Partnerships for School Health Education." *Journal of School Health,* 1989, Vol. 59, No. 1, pp.18-20.

Patton W.E., Allensworth, D.D. and London W. *A Handbook on Coalition Building and Program Development.* Chicago: National School Health Coalition, 1986.

Pentz, M.A. "Community Organization and School Liaisons: How to Get Programs Started." *Journal of School Health*, 1986; 56(9): 359-363.

Workshops and Publications are offered by the National School Public Relations Association, 1501 Lee Highway, Arlington, VA 22209, 703-528-5840.

Curriculum

National School Health Education Coalition. *Coalition Index: A Guide to School Health Education Materials.* Kent, OH: American School Health Association, 1986.

Centers for Disease Control. *A Compendium of Exemplary School Health Education Classroom Programs and Teaching and Learning Resources.* (A description of over 120 programs.) Center for Health Promotion and Education, PHS, 1600 Clifton Road, NE, Atlanta, GA 30333.

Hubbard, B.M., and Young, M. "An Evaluation of the Teenage Health Teaching Modules." *Health Values*, 1987, 12(1): 40-46.

Lloyd-Kolkin, D. and Hunter, L. *The Comprehensive School Health Sourcebook.* Menlo Park, CA: Health and Education Communication Consultants, 1990.

National Center for Health Education. *Growing Healthy.* New York: National Center for Health Education, 1986. (Curriculum Guide)

Seffrin, J.R. and Torabi, M.R. *Education in Healthy Lifestyles: Curriculum Implications.* Bloomington, IN: PDK Fastback Series no. 216, 1984.

Terhune, J. "Teaching Skills for Healthy Lifestyles." *Health Education*, Vol. 17, No. 1, pp. 4-7, October/November, 1984. (Curriculum Formation Guide)

US Department of Education. *Health and Physical Education Programs on the National Diffusion Network.* Washington, DC: US Department of Education, Office of Educational Research and Improvement, 1989.

Southwest Regional Educational Laboratory. *Criteria for Comprehensive Health Education Curricula.* Southwest Regional Educational Laboratory, 4665 Lampson Avenue, Los Alamitos, CA 90720, 213-598-7661.

National Cancer Institute/American Cancer Society. Nutrition education modules provide information and skill-based activities about making informed food choices.

US Department of Education. *Learning to Live Drug Free.* Washington, DC: US Department of Education, 1990.

President's Council on Physical Fitness and Sports. Provides materials on physical fitness topics, offers technical assistance, and holds annual clinics that serve as refresher courses for teachers, physical education professionals, and others.

Food and Nutrition Information Center, US Department of Agriculture. Nutrition education materials available through lending library.

American Heart Association. *Getting to Know Your Heart* (Elementary); *Heart Decisions* (Middle); *Heart Challenges* (High School). Curriculum support materials.

Wellness

Girdano, D.A. *Occupational Health Promotion: A Practical Guide to Program Development.* New York: Macmillan, 1986.

Higgins C.W. "Evaluating Wellness Programs." *Health Values: Achieving High Level Wellness,* October 1986, pp. 44-51.

Healthy School Environment

NSBA. *No Smoking: A Board Member's Guide to Nonsmoking Policies for the Schools,* 1987.

Orloske, A.J. and Leddo, J.S. "Environmental Effects on Children's Learning: How Can School Systems Cope." *Journal of School Health,* 1981, Vol. 51, No. 1, pp. 12-14.

National Cancer Institute/American Cancer Society. *Eat Smart, Think Smart.* A food manager's manual designed to facilitate changes in school lunch programs.

National Cancer Institute/American Cancer Society. *Smokeless Programs for Youth.* Guide to implementing school smoking education programs.

School Health Policy

Education Commission of the States. *State Policy Support for School Health Education: A Review and Analysis.* (Report 1821). Available from: Educational Services, American Council of Life Insurance, Health Insurance Association of America, 1850 K Street, NW, Washington, DC 20006.

Black, J.L. and Jones, L.H. "HIV Infection: Educational Programs and Policies for School Personnel." *Journal of School Health*, 1988, Vol. 58, No. 8, pp. 317-321.

Contact your State School Boards Association.

Funding Sources: Locating Support for School Health Programs

US Department of Education
Office of Education Research and Improvement
Fund for the Improvement and Reform of Schools and Teaching
555 New Jersey Avenue, NW
Washington, DC 20208-5524

US Department of Health and Human Services
Office of Disease Prevention and Health Promotion
Mary E. Switzer Building, Room 2132
330 C Street, NW
Washington, DC 20201
202-472-5560

Centers for Disease Control
Bldg. 3, B15, MS A14
1600 Clifton Road, NW
Atlanta, GA 30333
404-639-3824

National Institutes of Health
National Cancer Institute
National Institute of Child Health and Human Development
900 Rockville Pike
Bethesda, MD 20892

Foundation Directory
Foundation Center
888 7th Avenue
New York, NY 10106

Contact your State School Boards Association and your State Department of Education for additional information.

References

1. Committee for Economic Development, Research and Policy Committee, *Children in Need: Investment Strategies for the Educationally Disadvantaged.* New York: Committee for Economic Development, 1987.

2. Shannon, Thomas A. "Needed: Coordinated Services for Children." *The American School Board Journal*, February 1991, pp. 45-46.

3. McClain, Buzz. "Kids Dodge Exercise Craze," *The Journal Newspapers*, Fairfax, Virginia, February 5, 1991, p. B1.

4. Chiles, Lawton. Press Conference, Washington, DC: National Health-Education Consortium, April 29, 1990.

5. Vogel, P.G. *Effects of the Michigan Model for Comprehensive School Health Education on the Health Knowledge, Attitudes, and Behaviors of 5th Grade Children.* East Lansing, Michigan: Michigan State University, 1988.

6. Pollock, Marion D. and Hamburg, Marian V. "Health Education: The Basic of the Basics." *Why School Health Education?* Proceedings of the Delbert Oberteuffer Centennial Symposium, co-sponsored by the Office of Disease Prevention and Health Promotion, US Department of Health and Human Services, and the Association for the Advancement of Health Education, April 24, 1985, Atlanta, Georgia.

7. *Reducing the Risk: A School Leader's Guide to AIDS Education.* Alexandria, Virginia: National School Boards Association, 1990, p. 13.

8. O'Rourke, T.W. "The Need to Stimulate Quality Comprehensive Health Education Programs in All Schools." *Health Education*, October/November 1987, p. 22.

9. Allensworth, D.D. "Building Community Support for Quality School Health Programs." *Health Education*, October/November, 1987, p. 7.

10. *Ibid.*

11. Lohrman, D.K., Gold, A.S., and Jubb, W.H. "School Health Education: A Foundation for School Health Programs." *Journal of School Health*, December 1987, Vol. 57, No. 10, p. 422.

12. Pine, P. *Promoting Health Education in Schools—Problems and Solutions.* Arlington, Virginia: American Association of School Administrators, 1985, p. 31.

13. *Ibid*, p. 39.

14. Fors, S.W. and Doster, M.E. "Implication of Results: Factors for Success." *Journal of School Health*, October 1985, Vol. 55, No. 8, p. 333.

15. Aspry, D. and Roebuck, F. *Kids Don't Learn From People They Don't Like.* Amherst, Massachusetts: Human Resources Development Press, 1977, p. 40.

16. *Ibid*, p. 39.

17. Boyer, E.R. *High School: A Report on Secondary Education in America.* New York: Harper and Row, 1983, p. 111.

18. Aspry, D. and Roebuck, F. Op. cit., p. 28.

19. Parcel, G.S. "Skills approach to health education: A Framework for Integrating Cognitive and Affective Learning." *Journal of School Health*, 1976, Vol.46, No.7, pp. 403-406.

83

20. Connell, D.B., Turner, R.R., and Mason, E.F. "Summary of Findings of the School Health Education Evaluation: Health Promotion Effectiveness, Implementation, and Cost." *Journal of School Health*, 1985, Vol.55, No.8, p.316-321.

21. Lohrmann, D.K. and McClendon, E.F. "A Preliminary Study of Assumptions Underlying School Health Instruction." *Health Education Research*, 1987, Vol. 2, No. 2, pp. 131-144.

22. *Ibid.*

23. Pine, P. Op. cit., p. 28.

24. Walbert, H. "Health Knowledge and Attitude Change Before Behavior: National Evaluation of Health Programs Finds." *ASCD Curriculum Update*, Alexandria, Virginia: American Society for Curriculum and Development, June 1986, pp. 4-6.

25. Kolbe, L. and Green, L. "Appropriate Functions of Health Education in Schools: Improving Health and Cognitive Performance," in Krasnegor, N., Arasten, J., and Cataldo, M. (eds.). *Child Cognitive Behavior: A Behavioral Pediatrics Perspective.* New York: John Wiley, 1986.

26. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington, DC; US Department of Health and Human Services, Public Health Service, 1990, pp. 103-104.

27. Pate, R.R., Corbin, C.B., Simons-Morton, B.G., and Ross, J.G. "Physical Education and Its Role in School Health Promotion." *Journal of School Health*, December 1987; Vol. 57, No. 10, pp. 445-450.

28. Report D of the Council on Scientific Affairs, American Medical Association, presented in "Providing Medical Services through School-Based Health Programs," *Journal of School Health*, March 1990; Vol. 60, No. 3, pp. 87-91.

29. Keenan, T. "School-Based Adolescent Health Care Programs." *Pediatric Nurse*, Sept./Oct. 1986; Vol. 12, No. 5.

30. Schultz, E.W., Glass, R.M., and Kamholth, J.D. "School Climate: Psychological Health and Well-Being in School." *Journal of School Health*, December 1987; Vol. 57, No. 10, p. 435.

31. Connell, et al. Op. cit., pp. 319-321.

32. Seffrin, J.R. "Comprehensive School Health Curriculum: Closing the Gap Between State-of-the-Art and State-of-the-Practice." *Journal of School Health*, April 1990, Vol. 60, No. 4, p. 155.

Leadership Reports are one of the many benefits of the NSBA Direct Affiliate program. In addition to *Leadership Reports,* school board members and superintendents in NSBA Direct Affiliate school districts receive *School Board News*—the only national newspaper exclusively for school leaders— and NSBA's widely used National Education Policy Network. Individuals from Direct Affiliate districts also may also take advantage of substantial discounts on a variety of NSBA meetings, publications and services. Direct Affiliate fees support NSBA's advocacy program in Washington, D.C. and across the nation on behalf of local school districts.

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For more information on the *Leadership Reports* or NSBA's Direct Affiliate program, write or call the Direct Affiliate services staff of the National School Boards Association, 1680 Duke Street, Alexandria, VA 22314. (703) 838-6722.

about NSBA . . .

The National School Boards Association is located in Alexandria, Virginia, within the Washington, D.C., metropolitan area. NSBA is a not-for-profit organization whose primary mission is the general advancement of public education through the unique North American system of representative and participatory government, whereby elementary and secondary school policy is decided by local school board members who are directly accountable to the community. Over 95% are elected, and the remainder are appointed by elected officials.

Federation Members of NSBA are the state associations of local school boards, the Hawaii State Board of Education, and the boards of education in the District of Columbia and the U.S. Virgin Islands.

NSBA promotes the quality of public elementary and secondary schools through services to its Federation Members and local school boards; by increasing school board impact on federal education laws and regulations; and by maintaining liaison with other education organizations and governmental authorities.

In so doing, NSBA represents the interests of school boards before Congress, federal agencies and in court cases relating to education; provides education and training programs for school board members; provides school district management services; and offers to school boards a variety of other services including an annual convention and the Institute for the Transfer of Technology to Education (ITTE).

The NSBA Federal Relations Network, composed of up to five school board members in each Congressional district, plays a major role in NSBA's education advocacy program in Washington, D.C.

Three major publications are produced by NSBA: the award-winning monthly magazine, ***The American School Board Journal***; the monthly magazine, ***The Executive Educator***, and a fortnightly newspaper, ***School Board News***.

Constituent groups within the Federation play a significant role in NSBA's efforts to serve Federation Member and school board needs:

- The Council of Urban Boards of Education focuses on the needs of urban school boards.
- The Large District Forum serves the special needs of large but non-urban school districts.
- The Rural and Small District Forum serves rural and small enrollment districts.
- The Federation Member Executive Directors' NSBA Liaison Committee links the top executives within the Federation.
- The Council of School Attorneys focuses on issues of school law.
- The Conference of School Boards Association Communicators serves NSBA and Federation Member communications professionals.
- The Federal Policy Coordinators Network focuses on the administration of federally funded programs.
- The Technology Leadership Network serves as a forum for sharing information about technology in the classroom and school district operations.

NSBA maintains close liaison with other groups, such as the National Caucus of Black School Board Members, National Caucus of Hispanic School Board Members, National Caucus of Young School Board Members, National Association of State Boards of Education, American Association of School Administrators, Forum of Education Organization Leaders (FEOL), Educational Leaders Consortium (ELC), National Governors' Association, National Conference of State Legislatures, and Education Commission of the States.

Founded in 1940, NSBA represents the nation's 97,000 school board members who, in turn, represent the more than 40 million public school children in the U.S., who account for about 90% of all elementary and secondary school students in the nation. More than 2,000 local school boards are NSBA Direct Affiliates.

NSBA policy is determined by a 150-member Delegate Assembly composed of active school board members across the country. Translating this policy into action programs is a Board of Directors consisting of 21 members and three *ex-officio* members. The executive director administers NSBA programs, assisted by a professional staff.

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